OCCUPATION: A Medium of Inquiry for Students, Faculty & Other Practitioners Advocating for Health through Occupational Studies

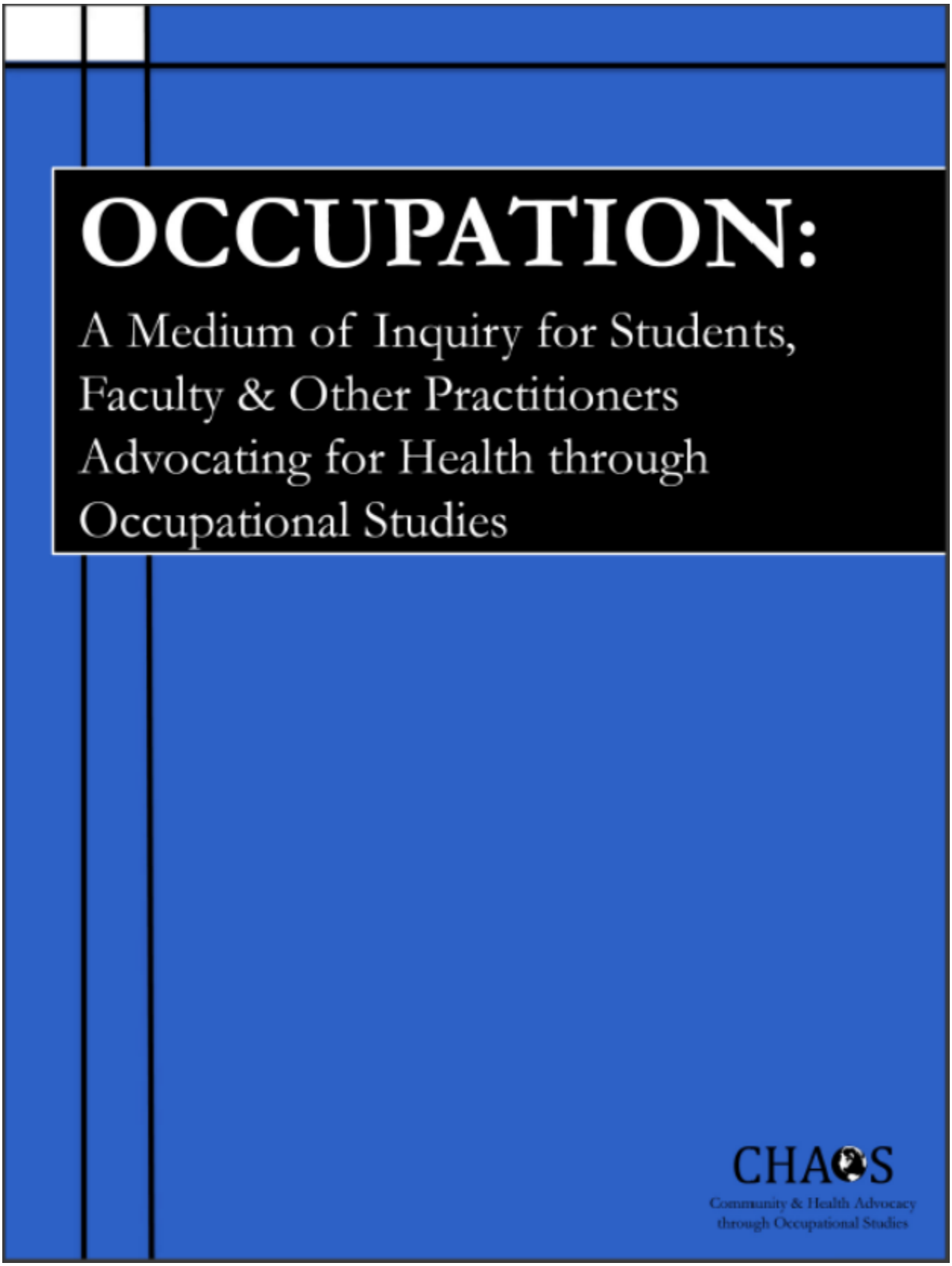
Volume 3
Issue 1 *December 2018*

Article 1

12-2018

December 2018 Issue

Occupation: December 2018 Issue



Occupation: December 2018 Issue

OCCUPATION: A Medium of Inquiry for Students, Faculty & Other Practitioners Advocating for Health through Occupational Studies

OCCUPATION: A Medium of Inquiry for Students, Faculty & Other Practitioners Advocating for Health through Occupational Studies is the official publication of Community & Health Advocacy through Occupational Studies. The mission is to serve as a medium to disseminate interprofessional scholarly work pertaining to occupational studies in the global community.

Publication Headquarters
Entry-Level Doctor of Occupational Therapy (OTD) Program
Nova Southeastern University - Tampa
College of Health Care Sciences, Department of Occupational Therapy
3632 Queen Palm Drive, Tampa, FL 33619-1378
P: 813.574.5340 / F: 813.574.5330

OCCUPATION: A Medium of Inquiry for Students, Faculty & Other Practitioners Advocating for Health through Occupational Studies

Occupation: December 2018 Issue

When Duty Calls: A Description of Human Conflict and Occupational Therapy

Bryce Carsone, OTD-S, and Jonathan Pitts, OTD-S

Nova Southeastern University

Abstract

As violent events escalate, even within the United States, it is imperative that occupational scientists have an in-depth understanding of the level one (descriptive) research implications, and occupational therapy practitioners are prepared to meet the needs of those impacted by conflict. This article aims to (a) describe the occupations of those affected by conflict (b) inform on current interventions through an intentional review (c) present the case for a call to action of occupational therapy practitioners. A general review of literature resulting in a description of occupations, identified four distinct populations: those who fight, caregivers, those who stay home, and the children. The intentional review provides examples of efficacious interventions for the identified populations. The overall call to action is supported by the evidence that occupational therapy practitioners are uniquely suited to utilize the power of occupational participation to not only minimize the impact of the disruption, but also to help mend communities that have been divided for the benefit of all who are involved.

Keywords: war, intervention, prevention, psychosocial

When Duty Calls: An Intentional Review of Human Conflict and Occupational Therapy

Introduction

Terrorist attacks, race wars, bombings- these words still loom over the world's psyche even in the most peaceful period in human history (Chasmar, 2016; Nesbit, 2016; Rodgers, Gritten, Offer, & Asare, 2016). These demonstrations of violence not only harm those who are directly involved but can be devastating to those that are caught in the crossfire (Waite, 2015). The resultant degradation can be witnessed in the occupational deprivation, or prolonged disengagement of needed or valued occupations due to environmental circumstances, of the communities and individuals (Whiteford, 2010). As violent events become more prevalent and publicized, occupational scientists and occupational therapy practitioners must do their part to ensure that the essence of occupation is maintained for those impacted (Marc, 2016). Occupational scientists must have an in-depth understanding of the level one (descriptive) research implications to elaborate on the scope of the occupational disruption and deprivation. Occupational therapy practitioners must be prepared to meet the needs of those impacted by conflict. This article aims to (a) describe the occupations of those affected by conflict (b) inform on current interventions through an intentional review and (c) present the case for a call to action of occupational therapy practitioners.

Methodology

Methodology of the General Review

Literature searched for the description of occupations and populations related to conflict came from the American Occupational Therapy Association (AOTA), Florida Occupational Therapy Association (FOTA), ProQuest, PubMed, and Google Scholar. Initial

database inquiries included the terms "war", "occupation", "effects", "home", and "children". The search resulted in a total of 1,536 articles with 26 being utilized due to the relevance and quality. The selected literature explores and analyzes the effects of war on occupations for all individuals impacted. It is through this holistic understanding of conflict's impact that occupational therapy practitioners can best use their unique skill set to begin the healing process.

Methodology of the Intentional Review

After the identification of the populations who are affected by conflict, an intentional review provided examples of efficacious interventions for the identified populations. Databases utilized included CINAHL, Medline, PubMed, PsychINFO, ProQuest, and Google Scholar with search terms "military", "health care provider", "family", "child", "war", "conflict", "treatment", "intervention", and "occupational therapy". Criteria for inclusion in this review were as follows: published after 2005, intervention conducted on one of the four populations identified in the article, intervention was within the scope of practice for occupational therapy. In total 4,476 were screened and eight articles were included in this review. This review is intended to provide a starting point for therapists who work with the populations mentioned in the search terms above and include those who fight, caregivers, those who stay home, and the children. See the PRISMA flowchart for further details.

General Review

Those Who Fight

The physical and emotional plight of men and women who experience war and conflict first-hand is well documented. Although occupational therapy practitioners are versed in

addressing physical ailments, the emotional injuries of these clients cannot be ignored. Conditions such as post-traumatic stress disorder (PTSD), bipolar disorder, depression, and substance abuse are the number one cause for hospitalization for men and the second leading cause for women (Keyes, 2010). Aside from traditional mental health ailments, men and women who directly participate in conflict can experience what are known as moral injuries (McGuirk, 2015). Moral injuries typically occur after reflection on one's own aggressive actions towards others, resulting in remorse and regret (McGuirk, 2015). For instance, when civilians are unintentionally harmed, those who inflicted the injuries may experience remorse that negatively impacts their daily life. Occupational therapy practitioners must understand the person on the battlefield is not a separate entity from the person that needs to be able to return to a productive civilian life once fighting has ceased.

The emotional trauma experienced by men and women who fight is often compounded by additional factors. For instance, United States military members may have several amenities when they are posted on base in foreign countries, but some of the most critical for well-being (internet service to communicate with family) are sparse (Cockerham, 2006). The constant, all-consuming demands on their psyche can extinguish their resiliency. The resulting occupational deprivation may contribute to these men and women's higher rate of suicide; an action with repercussions that last long after the conflict has subsided (Korb, 2007). Occupational therapy practitioners can use their unique skills to effectively reduce the negative impact of war and conflict and improve the mental health of these men and women.

Prevention is one of the most critical roles. Occupational therapy practitioners can use the power of participation to build resiliency factors for these clients, ultimately impeding the

development of mental health disorders (AOTA, 2016). This complex task must be handled with great care and diligence by the professional. When having to prioritize intervention or create therapeutic groups, one can note that while those who are exposed to warfare experience great hardship, those who also witnessed death have even more severe functional impairment (Wang, Lee, & Spiro, 2015). Basing interventions on exposure and exposure risks could help occupational therapy practitioners to effectively target the needs of this population while remaining client centered.

Environmental modification is another method of intervention that can be used to mitigate the negative effects of war. Allowing men and women on the battlefield to personalize their individual space (i.e. bunk bed, living quarters) can help to reinforce personal identity. In addition, soothing colors, quiet rooms, and places with dim lighting help to alleviate symptoms of post-traumatic stress disorder when applied to battlefield environments (Barris, 2016). These small changes in the environment can dramatically improve the psychological well-being of these individuals, as in keeping with the principles of well-being; create a sense of hope for the future, reinforce a personal identity, foster a sense of mastery over one's environment, and promote inclusion/community (Barris, 2016; Leamy, Bird, Le Boutiller, Williams, & Slade, 2011; Whaley, 2016).

Caregivers

Those who fight are not the only ones affected. Addressing the needs of healthcare professionals providing direct care to our military is an area not to be ignored. Health care providers face a plethora of barriers that hinder their ability to successfully participate in their valued occupations. For instance, health care providers contend with a lack of supplies. These

dire situations cause undue stress and require constant creativity and problem solving, yet they continue to occur on a regular basis without resolution (Tucker, 2009). The health care providers also report feeling alone, ostracized, scared, and disrespected (McMahon, Ho, Brown, Miller, Ansumana, & Kennedy, 2016). These emotional burdens have an immensely negative impact on their ability to provide quality care. Research has shown that these caregivers on the frontlines benefit most from structure, rest, exercise, and a healthy diet (Finnegan, Lauder, & McKenna, 2016). Occupational therapy practitioners can promote participation in these meaningful and necessary occupations, aiding caregivers in their fight to provide necessary services.

Those Who Stay Home

Civilians are being impacted by conflicts now more than ever (Marc, 2016). Historically, families had to cope with rationing and conscription into war work, such as machining (Goldin, 1991). This involuntary participation led to occupational imbalance and decreased well-being. Today, those who stay home may voluntarily choose to take on the new occupation of participating in war efforts. Although this occupational choice can hold value and meaning, dramatic occupational shifts cause stress and feelings of obligation.

Those who stay home, including those who do not participate in war efforts, are not always exempt from warfare exposure. Some people who experience this conflict will choose to leave their homes, becoming refugees. Those who are refugees are a population often neglected that experience some of the most detrimental impacts of occupational disruption and deprivation (Najla, 2016). Those who elect to stay face similar challenges. A regression analysis showed that women who were exposed to warfare reported greater functional

impairment than men who experienced similar conflict (Wang, Lee, & Spiro, 2015). Functional impairment in these studies most often equates to occupational disruption and deprivation as well. A study of women during war found that social support systems that reinforced self-concept, like those developed during psychosocial group occupational therapy, was most beneficial to diminishing these detrimental effects (Hobfoll & London, 1986).

Women are an important focus, not only for their own well-being, but for their children. Occupational deprivation caused by conflict has negative effects on the child's welfare, bonding, and well-being (Khamis, 2016). After the conflict ends, war can continue to have an adverse impact on children conceived by these women (Shachar-Dadon, Gueron-Sela, Weintraub, Maayan-Metzgar, & Leshem, 2016). Effects on the child can greatly impact child rearing and overall well-being of the parent, causing adverse effects to last long after conflict is resolved.

The Children

Children of parents who serve in the military have been referred to as, "those who need society's help the most" (Rossiter, D'Aoust, & Shafer, 2016, p. 109). Even children without military affiliation are not exempt from the hardships of war and conflict. They can lose years of schooling, creating lifelong disparage (Mottaghi, 2016). There are young people in this world who will be exposed to conflict throughout their entire lives. Research suggests that these individuals will eventually develop psychological immunization to the atrocities, but many argue that this reductionist view is not adequate in describing the full effects of conflict (Freh, 2015).

Children who involuntarily serve in aggressive groups may experience a wide array of traumatizing events in order to gain their submission to these aggressive groups. Such events

include isolation, intimidation, and destruction of independent identity (Kelly, Branham, & Decker, 2016). Children may also choose to participate in violent acts of conflict. Risk factors for children to voluntarily join an armed conflict include: wanting to escape bad life situations, not being able to achieve their goals, and agreeing with the philosophy of the armed group (Kohrt, Yang, Rai, Bhardwaj, Tol, & Jordans, 2016). Occupational therapy practitioners can help combat the negative effects of involuntary service and help to prevent voluntary enrollment by providing these clients with the opportunity to participate in age-appropriate occupations that are meaningful and healthful.

When working with this population, religious ideologies often emerge whether they were the original driving force behind the conflict or not. Occupational therapy practitioners must be client-centered and aware of religious beliefs of clients; however, be cautioned when utilizing this information. Although religion has been shown to have positive outcomes on youth impacted by war, the negative outcomes are just as well documented (Slone, Shur, & Gilady, 2016).

Overall, interventions for children who have been exposed to war and conflict are similar to more traditional occupational therapy services that focus on development and secure attachment. What may be less obvious is the fact that children will also benefit from the community cohesion that occupational therapy practitioners promote (Hanratty, Neeson, Bosqui, Duffy, & Connolly, 2016). Children who demonstrate resilience to aggressive events tend to be male, have greater problem-solving skills, have leisure activities, and have parental support (Fayyad, Cordahi-Tabet, Yeretzian, Salamoun, Najm, & Karam, 2016). Although the factor of gender cannot be changed, occupational therapy practitioners can work to increase

problem-solving, leisure participation, and parental support for children who have endured hardships due to war and conflict.

Intentional Review

Those Who Fight

Several effective interventions have been shown to help maintain or regain the health and well-being of soldiers who have experienced war and are within the scope of occupational therapy to perform. One area in which occupational therapy practitioners may help those who fight, is within Combat and Operational Stress Control (COSC) units. Occupational therapy practitioners in these units serve in uniform on the battlefield and are able to more effectively deliver care sooner, which can enable soldiers to return to the fight (Montz et al., 2008). Interventions that Army occupational therapy practitioners can provide include mental health counseling, wound care, and upper extremely care, and evaluation. Occupational therapy's involvement directly within the United States armed forces has had a documented positive effect on the return to duty rates while in the theatre of war (Smith-Forbes, Quick, & Brown, 2016).

Off the battlefield interventions have also been investigated and demonstrate efficacy. A recent randomized control trial of a new program called the Veteran Independence Program (VIP), targeted veterans who had sustained a traumatic brain injury (TBI) and sought to increase their social and community reintegration abilities (Winter et al., 2016). One of the key features of this intervention was that it involves a family member participating in the program alongside the veteran. The program sought to change parts of the environment which was done either over the phone or within the home. Veterans in the experimental group illustrated statistically

significant score improvement compared to those in the control (Winter et al., 2016). This study captured the effectiveness of this family-oriented program. When working with this population, it is then critical that the family support network is included in treatment.

Caregivers

Burnout and compassion fatigue are issues plaguing those who provide health care services to those who fight (Weidlich & Ugarriza, 2015). Recently, the Care Provider Support Program (CPSP) was established as a means to combat these barriers and promote successful participation for military health care providers. CPSP is a client-centered, interactive intervention that focuses on self-advocacy, action, and self-awareness over the 1- or 2-hour treatment session. Overall, Weidlich and Ugarriza (2015) found that CPSP was effective at reducing burnout, allowing practitioners to continue to provide necessary care for their patients.

Bingham, Inman, Walter, Zhang, and Peacock (2012) had similar findings when exploring the iRest intervention. Based in yoga and meditation, iRest is used to increase resilience and coping skills over 6 weeks. The study found that iRest significantly decreased stress, although it didn't significantly impact resilience, sleep, or burnout in the small sample (Bingham et al., 2012). In general, iRest may have the potential to benefit military health care providers, but this will remain unknown until further research and larger studies are conducted.

Those Who Stay Home

In the past, there have been few resources for those who stay home, even though they too experience the impacts of conflict and war. A recent article published by Gerwirtz, Erbes, Polusny, Forgatch, and DeGarmo (2011) focused on this gap in research and care, specifically

focusing on family cohesion and child-rearing. They advocate for the use of the Parent Management Training Oregon Model (PMTO), which reduces coercive parenting while promoting the five trademark practices of contingent skill encouragement, limit-setting, positive involvement, monitoring children's activities, and effective family problem-solving (Patterson, 2005). The PMTO has shown efficacy for high-stress families that lead to "reduced maternal depression, reduced maternal substance use, and reduce child substance use, increased income, reduced financial stress, and lower rates of police arrests for youngsters and mothers, all extending over a nine-year period" (Gerwirtz et al., 2011, p. 59; Forgatch, Patterson, DeBarmo & Beldavs, 2009; Patterson, DeGarmo, and Forgatch, 2004). Gerwirtz et al. (2011) suggested modification to the PMTO to promote client-centered practice for those who stay home during conflict. They proposd the newly designed After Deployment Adaptive Parenting Tools Program (ADAPT), which incorporates role play and audio-visual feedback, will further refine the PMTO for this population successfully (Gerwirtz et al., 2011).

Beardslee et al. (2011) conducted a similar efficacy study on a preventative program, the Families OverComing Under Stress (FOCUS). This program is a short-term intervention program that promotes coping for families during deployment. FOCUS supports resiliency factors while promoting strengths-based adaptation to constantly changing situations. Overall, the study found the intervention to be effective for the nine diverse sites studied (Beardslee et al., 2011).

The Children

Psychosocial and mental health treatments for children who are affected by violence have been evaluated in a systematic review performed by Jordans, Tol, Kompro, and De Jong

(2009). The review of 12 treatment outcome studies and 54 intervention descriptions suggested that interventions need to refocus on primary, rather than tertiary care. The most efficacious treatments were community-based and fostered developmentally appropriate resilience factors such as leisure participation and socialization (Jordans et al., 2009).

An example of efficacious tertiary treatment was conducted by Onyut et al. (2005) who evaluated the efficacy of Narrative Exposure Therapy (NET) for children who have survived war. NET involves reflection upon one's whole life while being guided in therapeutic expressions by a practitioner. The study found that NET resulted in lasting symptom reduction, which improved function for the participants (Onyut et al., 2005). Although the study took place in Africa and had a small sample size (limitations which are found in most efficacy studies for this population), NET has been shown to be effective in the treatment for people who have been exposed to conflict and trauma (Gwozdziewycz & Mehl-Madrona, 2013). Therefore, until further research can be produced, reliance on efficacy studies for similar diagnoses/risk factors can temporarily allow for assumed generalization of these results.

For a brief summary of the intentional review findings, see Table 1.

Discussion of Limitations

Occupational therapy practitioners are accustomed to utilizing meaningful occupations to enhance well-being. There is a need for purposeful occupations that can encompass the principles of doing, being, becoming, and belonging to promote health before, during, and after trauma occurs (Hitch, Pépin, & Stagnitti, 2014; Wilcock, 1999). Ultimately, further research of men who stay home and do not participate in conflict is warranted as well as efficacy studies of the recommendations made by this article. For the present time, there is consistent evidence

endorsing occupational therapy's role with the described populations. Another potential area for future study is community intervention. Occupational therapy practitioners may be called upon to utilize occupations as a means to bring opposing sides together to help resolve conflict or mend the divide once fighting subsides. This can be seen in Colombia where occupational therapy practitioners routinely work in the community, offering meal preparation and other co-occupations, to heal the wounds left by their Civil War so that residents can live in peace with one another (Waite, 2015). This niche practice area may become more prevalent in time as conflicts transition to be domestic rather than traditional international wars. It will be more critical than ever to help bring communities back together to prevent unnecessary trauma and death.

Conclusion

Those who fight may experience detrimental trauma during conflict situations (Keyes, 2010). In general, occupational therapy intervention recommendations center on preventative treatment such as environmental adaptation (AOTA, 2016; Barris, 2016). More specifically, occupational therapy interventions performed with those who fight during conflict (such as the those performed in COSC units) and after conflict (such as the VIP) have shown efficacy in promoting participation (Montz et al., 2008; Winter et al., 2016).

Those who provide health services on the frontlines may see traumatizing scenes; they also routinely have to contend with a lack of supplies and the resultant exhausting task of providing quality care in dismal conditions (Tucker, 2009). In general, occupational therapy intervention recommendations center on providing occupational balance and structured routines (Finnegan et al., 2016). More specifically, occupational therapy interventions

performed with those who are health care providers (such as the CPSP and iRest) have shown efficacy in facilitating occupational participation (Bingham et al., 2012; Weidlich & Ugarriza, 2015).

Those who stay home or choose to flee their country seeking refuge, face functional impairment (Najla, 2016; Wang, Lee, & Spiro, 2015). In general, occupational therapy intervention recommendations center on providing social support that reinforces self-concept (Hobfoll & London, 1986). More specifically, occupational therapy interventions performed with those who do not fight (such as the PMTO and FOCUS) have shown efficacy in promoting occupational performance (Beardslee et al., 2011; Gerwirtz et al., 2011).

The children who participate in conflicts and those whose parents partake in aggressive action may experience developmental delays imposed by their context (Mottaghi, 2016). Thus, occupational therapy intervention recommendations generally center on developmental milestones, secure attachment, and community cohesion that will provide opportunities for critical experiences (Hanratty et al., 2016). More specifically, occupational therapy interventions performed with children who are impacted by war and conflict (such as the NET and those that are community and prevention-based) have shown efficacy in promoting occupational participation (Jordans et al., 2009; Onyut et al., 2005).

Although occupational therapy is still trying to regain its footing within mental health, it is not difficult to see its role within crisis situations. War inherently causes occupational disruption, which exponentially magnifies the already detrimental impacts of conflict (Whiteford, 2010). Occupational therapy practitioners are uniquely suited to utilize the power of occupational participation to not only minimize the impact of the disruption, but also to help

mend communities that have been divided for the benefit of all who are involved. Overall, occupational therapy has a critical role to play during conflict and it is the profession's moral imperative to respond when duty calls.

References

American Occupational Therapy Association. (2016). *Veterans' and Wounded Warriors' mental health*. Retrieved from http://www.aota.org/Practice/Mental-Health/Emerging-Niche/Veteran.aspx

Barris, K. (2016). *Designing healing environments in Veteran housing for those coping with Post-Traumatic Stress Disorder* (Master's thesis, California State University). Retrieved from http://scholarworks.csun.edu/handle/10211.3/161170

Beardslee, W., Lester, P., Klosinski, L., Saltzman, W., Woodward, K., Nash, W., … Leskin, G. (2011). Family-centered preventive intervention for military families: Implications for implementation science. *Prevention Science*, *12*(4), 339-348. doi:10.1007/s11121-011-0234-5

Bingham, M., Inman, A., Walter, J., Zhang, W., & Peacock, W. (2012). Improving stress and resilience for military healthcare providers: Results from a pilot study. *BioMed Central*, *12*(Suppl. 1), 69. doi:10.1186/1472-6882-12-S1-P69

Chasmar, J. (2016). *Obama: We're living in the "most peaceful" era in human history*. Retrieved from http://www.washingtontimes.com/news/2016/apr/26/obama-were-living-in-most-peaceful-era-in-human-hi/

Cockerham, S. (2006). Soldiers learn art of homemaking at war. *The News Tribune*, *15*(9), A01.

Fayyad, J., Cordahi-Tabet, C., Yeretzian, J., Salamoun, M., Najm, C., & Karam, E. G. (2016). Resilience-promoting factors in war-exposed adolescents: An epidemiologic study. *European Child and Adolescent Psychiatry*. doi:10.1007/s00787-016-0871-0

Finnegan, A., Lauder, W., & McKenna, H. (2016). The challenges and psychological impact of delivering nursing care within a war zone. *Nursing Outlook*, *64*(5), 450-458. doi:10.1016/j.outlook.2016.05.005

Forgatch, M. S., Patterson, G. R., DeGarmo, D. S., & Beldavs, Z. G. (2009). Testing the Oregon delinquency model with 9-year follow-up of the Oregon Divorce Study. *Development and Psychopathology*, *21*, 637-660.

Freh, F. M. (2015). Psychological effects of war and violence on children. *Journal of Psychological Abnormalities*, *S1*(e001). doi:10.4172/2329-9525

Gerwirtz, A. H., Erbes, C. R., Polusny, M. A., Forgatch, M. S., & DeGarmo, D. S. (2011). Helping military families through the deployment proves: Strategies to support parenting. *Professional Psychology: Research and Practice*, *42*(1), 56-62. doi:10.1037/a0022345

Goldin, C. D. (1991). The role of World War II in the rise of women's employment. *The American Economic Review*, *81*(4), 741-756.

Gwozdziewycz, N., & Mehl-Madrona, L. (2013). Meta-analysis of the use of Narrative Exposure Therapy for the effects of trauma among refugee populations. *Permanente Journal*, *17*(1), 70-76. doi:10.7812/TPP/12-058

Hanratty, J., Neeson, L., Bosqui, T., Duffy, M., & Connolly, P. (2016). *Psychosocial interventions for reducing the harmful effects of war and conflict-related violence on young children aged 0-11 years (Protocol)*. Poster session presented at the 11th Annual Cochrane Collaboration in Ireland Conference, Belfast, United Kingdom.

Hitch, D., Pépin, G., Stagnitti, K. (2014). In the footsteps of Wilcock, part one: The evolution of doing, being, becoming, and belonging. *Occupational Therapy in Health Care*, *28*(3), 231-246. doi:10.3109/07380577.2014.898114

Hobfoll, S. E., & London, P. (1986). The relationship of self-concept and social support to emotional distress among women during war. *Journal of Social and Clinical Psychology*, *4*(2), 189-203.

Jordans, M. J. D., Tol, W. A., Komproe, I. H., & De Jong, J. (2009). Systematic review of evidence and treatment approaches: Psychosocial and mental health care for children in war. *Child and Adolescent Mental Health*, *14*(1), 2-14. doi:10.1111/j.1475-3588.2008.00515.x

Khamis, V. (2016). Does parent's psychological distress mediate the relationship between war trauma and psychosocial adjustment in children? *Journal of Health Psychology*, *21*(7), 1361-1370. doi:10.1177/1359105314553962

Kohrt, B. A., Rai, S., Tol, W. A., Minyoung, Y., Bhardwaj, A., & Jordans, M. D. (2016). Recruitment of Child Soldiers in Nepal: Mental Health Status and Risk Factors for Voluntary Participation of Youth in Armed Groups. *Peace & Conflict*, *22*(3), 208-216. doi:10.1037/pac0000170

Korb, L. J. (2007). *Quality of life in the military*. Retrieved from https://www.americanprogress.org/issues/security/report/2007/12/20/3739/quality-of-life- in-the-military/

Kelly, J. T., Branham, L., Decker, M. R. (2016). Abducted children and youth in Lord's Resistance Army in Northeast Democratic Republic of the Congo (DRC): Mechanisms of indoctrination and control. *Conflict Health*, 10-11. doi:10.1186/s13031-016-0078-5

Keyes, C. (2010). *Growing mental health problems in military*. Retrieved from http://www.cnn.com/2010/US/12/09/military.mental.problems/index.html

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*, 445-452. doi:10.1192/bjp.bp.110.083733

Marc, A. (2016). *Conflict and violence in the 21st century*. Retrieved from http://www.un.org/pga/70/wp-content/uploads/sites/10/2016/01/Conflict-and-violence-in-the-21st-century-Current-trends-as-observed-in-empirical-research-and-statistics-Mr.-Alexandre-Marc-Chief-Specialist-Fragility-Conflict-and-Violence-World-Bank-Group.pdf

McGuirk, A. E. (2015). 9/11 War Stories: Between Therapy and Critique. *The Penn State McNair Journal*, *20*, 65-76. Retrieved from http://forms.gradsch.psu.edu/diversity/mcnair/mcnair_jrnl2015/files/PSU-McNair-Vol20.pdf#page=73

McMahon, S. A., Ho, L. S., Brown, H., Miller, L., Ansumana, R., & Kennedy, C. E. (2016). *Healthcare providers on the frontlines: A qualitative investigation of the social and emotional impact of delivering health services during Sierra Leone's ebola epidemic*. Retrieved from http://heapol.oxfordjournals.org/content/early/2016/06/07/heapol.czw055.full.pdf+html

Montz, R., Gonzales, F. J., Bash, D., & Carney, A. (2008). Occupational therapy role on the battlefield: an overview of combat and operational stress and upper extremity rehabilitation. *Journal of Hand Therapy*, *21*(2), 130-136.

Mottaghi, L. (2016). *The impact of war and peace in Mena*. Retrieved from http://siteresources.worldbank.org/INTMENA/Resources/QN155.pdf

Najla, H. (2016). *Experiences of Bosnian War-Survivor Refugees: Implications for Counselor Multicultural Competence* (Doctoral dissertation, State University of New York at Buffalo). Retrieved from http://gradworks.umi.com/10/12/10127768.html

Nesbit, J. (2016). *American has a big race problem*. Retrieved from http://www.usnews.com/news/articles/2016-03-28/america-has-a-big-race-problem

Onyut, L. P., Neuner, F., Schauer, E., Ertl, V., Odenwald, M., Schauer, M., & Elbert, T. (2005). Narrative exposure therapy as treatment for child war survivors with posttraumatic stress disorder: Two case reports and a pilot study in an African refugee settlement. *BioMed Central Psychiatry*, *5*(7), 1-9. doi:10.1186/1471-244X-5-7

Patterson, G. R. (2005). The next generation of PMTO models. *The Behavior Therapist*, *28*, 27-33.

Patterson, G. R., DeGarmo, D., & Forgatch, M. S. (2004). Systematic changes in families following prevention trials. *Journal of Abnormal Child Psychology*, *32*, 621-633.

Rodgers, L., Gritten, D., Offer, J., & Asare, P. (2016). *Syria: The store of the conflict*. Retrieved from http://www.bbc.com/news/world-middle-east-26116868

Rossiter, A. G., D'Aoust, R., & Shafer, M. R. (2016). Military serving at what cost? The effects of parental service on the well-being of our youngest military members. *Annual Review of Nursing Research*, *34*, 109-117. doi:10.1891/0739-6686.34.109

Shachar-Dadon, A., Gueron-Sela, N., Weintraub, Z., Maayan-Metzger, A., & Leshem, M. (2016). Pre-conception war exposure and mother and child adjustment four years later. *Journal of Abnormal Child Psychology*. Retrieved from http://link.springer.com/article/10.1007/s10802-016-0153-9

Slone, M., Shur, L., & Gilady, A. (2016). Youth exposed to terrorism: The moderating role of ideology. *Current Psychiatry Reports*, *18*(5), 44. doi:10.1007/s11920-016-0684-3

Smith-Forbes, E. V., Quick, C. D., & Brown, K. M. (2016). Roles of occupational therapy practitioners in Theater, Past and Present. *U.S. Army Medical Department Journal*, 66-70.

Tucker, A. L. (2009). *Workarounds and resiliency on the front lines of health care*. Retrieved from https://psnet.ahrq.gov/perspectives/perspective/78#

Waite, A. (2015). OT Around the world: Profiles of occupational therapy practitioners in South America, Europe, the Middle East, Africa, and Asia. *OT Practice*, *21*(1), 8–12.

Wang, J. M., Lee, L. O., & Spiro, A. (2015). Gender differences in the impact of warfare exposure on self-rated health. *Women's Health Issues*, *25*(1), 35-41. doi:10.1016/j.whi.2014.09.003

Weidlich, C. P., & Ugarriza, D. N. (2015). A pilot study examining the impact of care provider support program on resiliency, coping, and compassion fatigue in military health

care providers. *Association of Military Surgeons of the United States*, *180*(3), 290-295. doi:10.7205/MILMED-D-14-00216

Whaley, M. (2016). Effect of a spinal cord injury navigator on pressure ulcer knowledge. Buzz session presented at the annual Florida Occupational Therapy Association Conference.

Whiteford, G. (2010). Occupational deprivation: Understanding limited participation. In C. H. Christiansen & E. A. Townsend (Eds.), *Introduction to occupation: The art and science of living* (2nd ed., pp. 242-267). Upper Saddle River, NJ: Pearson Education, Inc.

Wilcock, A. A. (1999). Reflections on doing, being, and becoming. *Australian Occupational Therapy Journal*, *46*(1), 1-11. doi:10.1046/j.1440-1630.1999.00174.x

Winter, L., Moriarty, H. J., Robinson, K., Piersol, C. V., Vause-Earland, T., Newhart, B., & ... Gitlin, L. N. (2016). Efficacy and acceptability of a home-based, family-inclusive intervention for veterans with TBI: A randomized controlled trial. *Brain Injury*, *30*(4), 373-387. doi:10.3109/02699052.2016.1144080

Figure 1. Intentional Review Methodology PRISMA Flowchart

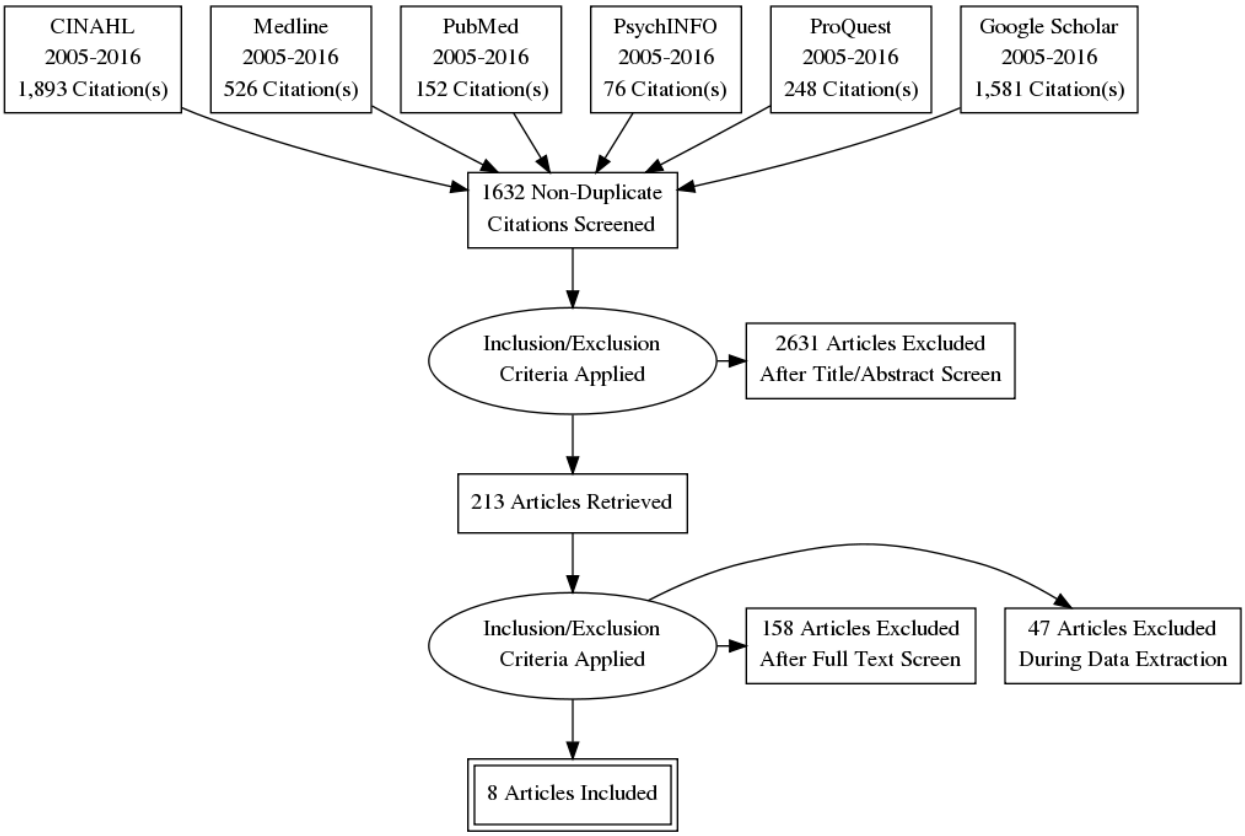


Table 1. Intentional Review Evidence Table

Study	Location	Design	Measures	Demographics	Outcomes
Occupational therapy role on the battlefield: An overview of combat and operational stress and upper extremity rehabilitation	United States	Descriptive Review	N/A	Active United States Military Members	Occupational therapy has a key role to play in helping military members
Efficacy and acceptability of a home-based, family-inclusive intervention for veterans with TBI: A randomized controlled trial	United States	Randomized Control Trial	1. Community Integration 2. Veteran self-identified 3. Self-Rated Functional Competency	N=81 Veterans and their families	A home-based program the includes families has shown to be more effective than control therapy
A pilot study examining the impact of care provider support program on resiliency, coping, and compassion fatigue in military health care providers	United States	Prospective Pilot Study	1. Connor-Davidson Resilience Scale 2. Ways of Coping Questionnaire 3. Professional Quality of Life Questionnaire	N=93 Healthcare providers 28 completed follow up	CPSP intervention was significant for reducing burnout among caregivers
Improving stress and resilience for military healthcare providers: Results from a pilot study	United Sates	Pilot Pre-Post test	Stress, sleep, resilience, burnout, compassion and satisfaction	N=14 Health Care Providers	iRest decreased stress significantly

Helping military families through the deployment proves: Strategies to support parenting	United States	Model Description	N/A	Military Families	Shows Efficacy for PMTO model for reducing stress and makes case for ADAPT for Military families
Family-centered preventive intervention for military families: Implications for implementation science	United States	Intervention Description and Implication	Self-report	Military Families	FOCUS is a flexible, responsive and efficient preventative program for military families
Systematic review of evidence and treatment approaches: Psychosocial and mental health care for children in war.	United States	Systematic Review	N/A	Children affected by War	Primary care should be focused on; more research is needed.
Narrative exposure therapy as treatment for child war survivors with posttraumatic stress disorder: Two case reports and a pilot study in an African refugee settlement.	Somalia Africa	Pre-Post test	CIDI Sections K and E	Children with PTSD	NET resulted in significant symptom reduction in both the post-test and the follow up.

Occupation: December 2018 Issue

The Interprofessional Exploration of Occupational Deprivation (OD) in Intimate Partner Violence (IPV) to inform the Health Professional

Chane' Wray OTD-S & Cheryl Mae Granada OTD-S

Nova Southeastern University

Abstract

One of the most common forms of violence against women is intimate partner violence (IPV), a public health issue affecting one in three women globally and one in four in the nation (World Health Organization [WHO], 2016). IPV produces long-term impressions as it is defined as any behavior within an intimate relationship that causes physical, psychological or sexual harm (WHO, 2016). Women affected by IPV are inclined to isolate themselves socially decreasing their participation in daily routines (Gorde et al., 2004). The prolonged preclusion of women from necessary/meaningful occupations such as child rearing and social interaction is a conflict outside their control and is identified as occupational deprivation (OD) (Whiteford, 2010). This problem concerns different disciplines such as psychology, nursing, social work, law enforcement, and occupational therapy. The authors of this exploratory paper searched the databases of EBSCOHost, ProQuest, and Google Scholar to identify articles relevant to the topic from a variety of fields. Limitations of these studies included articles geared to (a) violence against women (b) violence occurring within heterosexual relationships (c) specific IPV service providers (d) proposed solutions for programs within the United States. This exploratory paper investigates the OD of women affected by IPV by understanding the perspectives, experiences, and recovery process to inform health professionals when working with survivors of IPV. Overall there is a need for collaboration among disciplines to further address OD in IPV.

Keywords: IPV, occupational deprivation, occupation, interdisciplinary

Occupation: December 2018 Issue

The Interprofessional Exploration of Occupational Deprivation (OD) in Intimate Partner Violence (IPV) to inform the Health Professional

Globally, violence against women is at an all-time high (World Health Organization [WHO], 2016). The most common type of violence affecting women is called intimate partner violence (IPV). IPV produces long-term impressions as it is defined as any behavior within an intimate relationship that causes physical, psychological, or sexual harm; One in three women have reported experiencing IPV within a relationship, thereby characterizing IPV as a major health concern and a significant violation of women's human rights (WHO, 2016). Women affected by IPV are inclined to isolate themselves socially, decreasing their participation in daily routines (Gorde, Helfrich, & Finlayson, 2004). The prolonged preclusion of women from necessary/meaningful occupations such as child rearing and social interaction is a conflict outside of their control due to the fear, control, and power of their intimate partner. This is identified as occupational deprivation (OD) (Whiteford, 2010). OD as a construct is a type of occupational injustice, which Wilcock (1998) describes as stemming from the belief that not all people are afforded equal opportunities to participate in occupations of choice. Deprivation from occupations has demonstrated irreparable consequences to health and wellbeing of the individual (Backman, 2010). External factors including those that are social, economical, environmental, geographic, historic, cultural, or political in nature are all known to produce incidences of OD. IPV may be characterized by one or several of these external factors, therefore, various disciplines including, but not limited to psychology, nursing, social work, law enforcement, and occupational therapy have a role in addressing associated factors within OD,

and the dangers of IPV on women. This exploration of the literature aims to understand the global perspective of IPV, the individual's personal experience, and the process of recovery in relation to OD in order to inform the health professional on current issues and potential areas of development within the scope of IPV prevention and management.

Problem Statement

IPV is a major health concern often overlooked. At this time there is a lack of literature available that explores the occupational deprivation of women affected by intimate partner violence (IPV), and an even greater need of literature that address IPV across disciplines in order to better inform the health professional.

Objectives

1. To explore the connection between disciplines concerned with OD in women affected by IPV.
2. To pose solutions in bridging the gap between disciplines concerned with OD in women affected by IPV.

Methodology

The search terms used in the exploratory paper include IPV, occupational deprivation, occupation, and interdisciplinary. The databases EBSCO Host, ProQuest, AJOT, and Google Scholar were utilized. From the following articles generated in each database, the articles that focused on women in heterosexual relationships were reviewed followed by articles that explored IPV effects on occupations. The next step were to review articles published after the year 2000 and within the following professions; nursing, occupational therapy, social work,

psychology, and law enforcement. Our final review consisted of articles commenting on all the above criteria along with the perspectives, experiences, and recovery of women affected with IPV.

Exploration of the Literature: The Results

Through the exploration of the literature three major concerns emerged that were seen to affect the manifestation of IPV. These included a skewed social perspective of IPV globally, a misunderstanding of the victims lived experience of IPV, and barriers preventing successful recovery. Clarity about these three concerns will aid in a better understanding of the phenomenon of IPV by various health professionals. In addition, clarification may assist health professionals a sequential understanding of IPV (perspectives, experiences, and recovery), which may assist service providers a better appreciation of their professional role and obligations when working with victims of IPV. While exploring the occupational science construct of OD, there was a lack of research to inform the health professional. The gap in the literature may be filled by descriptive and followed by relational research. For example, descriptive research will aid in providing an evidence base for the lived experience of IPV, while relational research will aid in building a collaborative approach to care for victims of IPV.

Understanding the perspectives of IPV

The WHO (2016) has recognized the unequal position of men and women, and the use of violence to resolve conflict within a relationship to be a typical factor of IPV. Multi-country studies report community minimization of IPV, which supports the perpetrator opposed to victim cyclical factors in the continuance of abuse. This is seen in the deep-rooted community

norms pertaining to respect and family values; factors which pose a barrier to women seeking help (Sullivan, Nguyen, Allen, Bybee, & Juras, 2005; Hyman et al., 2006). This manifestation of sex-role stereotyping exemplifies the social and cultural judgments made about the expectations of men and women in society; these traditional ideologies on gender roles and male dominance have not only been shown to increase occurrence of IPV but also have been shown to deprive women from engagement within occupations (Whiteford 2010; WHO, 2016). Understanding the social perspectives of IPV is important in addressing the issue of OD in women affected by abuse as the social context influences occupations at the individual level (Iwama, 2010). Therefore, to address occupations at the individual level we must also explore the experience of IPV.

Understanding the experiences of IPV

It is readily misunderstood why women who are victim to IPV remain in a relationship with their perpetrator. Research suggests most women stay in abusive relationships when faced with IPV because many times men are inclined to use tactics that threaten life and inhibit partner autonomy (Hamberger & Larsen, 2015). Current research reports women are more likely to be physically abused when faced with IPV (Hamberger & Larsen, 2015). One study sampled injuries of both sexes in the emergency room produced from IPV and reported that women were more likely than men to sustain injuries and reported higher rates of lifetime and in-past-year injury than men (Phelan et al., 2005). Another study looked at the type of injuries incurred in women battered by IPV and reported women suffered more central nervous system injuries, internal injuries, broken bones, broken teeth, burns, scratches, bruises, and welts whereas men suffered more lacerations and cuts (Arias & Corso, 2005). Consequently, women

who sustain such injuries from physical abuse are more likely to try to conceal signs of injury by isolating themselves from the community, resulting in a decrease in participation of daily routines (Humbert, Englemen, & Miller, 2014). Physical abuse is not the only area of concern as psychological abuse is the most common and unforeseen cause of IPV (WHO, 2016). Emotional abuse has been described as controlling the woman, calling the woman inappropriate names, and disrespecting the woman's belongings along with verbal threats (Hyman et al., 2006). Such tactics increase already prevalent person factors such as low self-esteem, insecurity, and depression (Centers for Disease Control and Prevention, 2016). Occurrences of physical, psychological, and sexual trauma resulting from IPV are all significant causes in the deprivation of social participation and causes an inability to maintain function within areas of health management and maintenance.

Studies have shown young couples' reliance on one another for socioemotional support and direct financial assistance is a major reason why abuse is prolonged in women (Copp, Giordano, Manning, Longmore, 2016). Moreover, immigrants experience IPV at significantly higher rates due to the increased need for the aforementioned supports. Their experience with IPV is emphasized by the affliction of having to adapt to a new area while also experiencing isolation (Hamberger & Larsen, 2010). Women from Ethiopia describe isolation as a significant factor in their experience with IPV as the perpetrator did not allow them to go to school, learn English, visit others or even leave the house without permission (Sullivan et al., 2005). Such constraints limit the victim's ability to pursue the occupations of education and work, increasing the need for partner dependence.

Unsupportive social environments further prolong partner dependency. Within many cultures, it is known that IPV occurs and it continues to be an accepted practice (Sullivan et al., 2005). These social environments perpetuate IPV and make women ashamed to talk about their experience of abuse to others (Bacchus et al., 2016). Women immigrants continue to be especially susceptible because their social environment is non-existent as many times all their social supports are far away (Sullivan et al., 2005). There is also a systems advantage described as the government (immigration officials, welfare, child support, public housing, etc.) that leaves legal assets to be controlled by the man (perpetrator) who helped bring the woman immigrant (victim) to the area (Sullivan et al., 2005). Consequently, OD and IPV are often heightened by restriction to such resources.

Women affected by IPV who lack social and financial resources are often chained to the physical environment of an abusive household (Zufferey et al, 2016). Limited availability of housing separate from perpetrator, inability to make housing payments alone, poor rental history, bad credit, or criminal histories prevent women affected by IPV from obtaining housing on their own (Clough, 2014). Additionally, a woman who attempts to escape an abusive household and has a child/children is also challenged with providing a safe home environment for her child/children (Meyer, 2012), which makes the occupation of child rearing particularly difficult. Children were reported to be the most commonly mentioned factor inhibiting women from leaving an abusive relationship. In addition, most women base such decisions on what they believed was best for their children (i.e. keeping the family together or protecting the child/children from partner threats) (Meyer, 2012). Child rearing further complicates IPV as women are often constrained from seeking help as the primary caregivers within the family

(Sullivan et al, 2005). This is a conflict for women who are in IPV relationships and women who are recovering from IPV.

Understanding the Recovery of IPV

Women who have managed to leave abusers are not yet emancipated. IPV produces long lasting effects on the emotional, psychological, and physical being of the individual, suggesting that various disciplines hold a significant role not only in understanding, but also in aiding in victim recovery. Recovery can be defined as the process of leaving an abusive relationship and the reclaiming of one-self. Eight participants interviewed in-depth using the Kawa Model and associated river drawings identified ideals of gaining self-reliance, inner strength, self-sufficiency, and self-love as productive to the process of recovery (Humbert et al., 2014). Success in recovery requires addressing person factors associated with high risks of IPV must be addressed. Low self-esteem, emotional dependency, and depression are correlated highly with IPV and return to abusive spouses; therefore, restoring empowerment to the victim through self-worth is essential to recovery (Centers for Disease Control and Prevention, 2016). Establishing self-worth for victims requires collaboration among professionals to encourage standards of non-tolerance through education and social supports.

Education is an indispensable resource for women who are experiencing IPV or who are in the recovery phase of IPV. Education not only grants women academic knowledge, but also provides education that will encourage social empowerment, self-confidence, and the ability to use information and resources available in society (Jewkes, 2002). Skills accumulated through educational resources have the possibility to translate into financial wealth, which furthers empowerment for women experiencing IPV (Jewkes, 2002). Education surrounding health

information and women's rights is essential to recovery, as many who experience IPV, specifically immigrants, are unaware of what constitutes intimate partner violence and what legal actions are available during or after experiencing IPV (Sullivan et al., 2005). Education that raises IPV knowledge will assist victims in identifying and distinguishing between healthy and unhealthy relationships, preventing women from returning to abusers or entering abusive partnerships in the future (Bacchus et al., 2016).

Women who establish strong social supports are less likely to experience isolation and return to an abusive relationship therefore healthy social participation is necessary occupation of recovery (Jewkes, 2002). Research has identified supportive services essential to achieving stability after experiencing IPV and recovery setbacks (Sullivan et al., 2005). Women who have experienced IPV significantly report feeling re-victimized and stigmatized when turning to agencies for assistance (Sullivan et al., 2005; Bacchus et al., 2016). Providing trusted professionals who are readily available to help allows the victim to comfortably talk about their experience to non-family members who can provide non-judgmental and objective advice (Bacchus et al., 2016). Furthermore, social support provides the victim with resources for housing, employment, and organizations in which access was previously restricted. However, agencies who are unfamiliar with the victim's roles and occupations may require additional, timely requirements from the victim that prohibit them from obtaining services critical to their recovery (Sullivan et al., 2005). An interdisciplinary team approach including social workers, occupational therapists, psychologists, family counselors, and law enforcement teams whom are trained in providing client-centered care may be ideal in providing the individualized care for women recovering from IPV.

Reflection

The outstanding paucity of literature pertaining to IPV and its impact on occupation reflects the challenges health disciplines, including occupational science face in addressing physical, psychological, and sexual abuse. This theoretical exploration accentuates the need for different levels of occupational science research, starting with descriptive, and slowly moving up the relational and later higher levels intended to progressively promote awareness and establish guiding evidence on the correlation of, and interventions for IPV and OD.

Comprehensive understanding of IPV requires increased data collection from women who have been a victim of abuse, as well as increased collaboration between professionals including occupational therapists, social workers, psychologists, legal teams, and occupational scientists who are able to collect, interpret and analyze data necessary to implement prevention and intervention strategies therapeutic to occupational restoration. Thorough reflection on each discipline's role within IPV management is the first step in global collaboration and action against OD.

Restoration for victims of IPV lies in global efforts of professionals in multiple contexts to promote awareness and advocate for women's rights as well as strengthen community responses to violence against women. Lack of, and poor social supports were identified as perpetuating factors in the occurrence of IPV, therefore, social workers play a vital role in providing supports necessary to aid in the recovery of OD. As counselors, case managers, and advocates social workers provide services that prevent crises, help individuals cope with everyday stressors, and support community needs (Edleson, Lindhorst, & Kanuha, 2015). Social workers assist in the restoration process by identifying and obtaining services advantageous to

occupational participation. For victims of IPV such services include providing reliable and affordable childcare, housing, and employment, for successful occupational participation in areas of child rearing, home management, education, and work. However, social workers remain stagnant in their imperative role in the screening and assessment of IPV which holds significant implications for identifying victims (Murphy & Quimet, 2008), improvements is this area may aid in preventing further occurrences of occupational deprivation.

Law enforcement and health professionals also play an active role in responding to and providing help for women experiencing abuse. Officers are routinely first call responders in instances of domestic disputes (Cerulli, Edwardson, Hall, Chan, & Conner, 2015), and similarly as health care providers nurses have the opportunity to screen first hand and detect IPV (Daniel & Milligan, 2013). However, the issue lies in poor response training, as professionals sometimes lack the knowledge about the dynamics of the violence and its impact on the individuals within the household (Blaney, 2010). These professions have a significant influence on the occurrence and continuance of IPV as they work to identify and prevent injuries that later restrict women from engaging in social participation, which in turn may discourage efforts to seek help and occupational restoration from the community or other health professions.

Understanding IPV requires understanding the significant impacts on mental health. Profoundly entrenched social and cultural perspectives as well as varying contextual factors motivate IPV; psychologists play a role in understanding psychopathology and neuropsychopathology in the perpetration of abuse (Corvo & Johnson, 2013). The role of psychologists may include addressing a family history of violence, academic history (Lohman et al., 2013) and mental health diagnoses. Understanding such factors will not only be beneficial in

providing recovery to victims, but also in understanding perpetrators and their motives, to aid in early detection and prevention of IPV.

A key issue of IPV is the pattern of abusive behavior by the abuser to establish fear, power, and control over an intimate or formerly intimate partner (American Occupational Therapy Association [AOTA], 2007). This issue affects how any individual performs in their activities of daily living and occupational roles and signifies a need for occupational therapy professionals. Research has supported the relationship between women affected by IPV and their occupations, however they have not yet explored the facets of their different occupations throughout the course of IPV. Such implications include job exploration (Chronister & McWhirter, 2003), self-care, financial management (Gorde et al., 2004), and child rearing (Sullivan, 2005). There may be fewer studies focusing on the implications of IPV with occupational roles such as being a homeowner in negotiating a safe home (Zufferey et al., 2016) and in many cultures, being a wife/respected member of society (Hyman et al., 2006). Lastly there is need of research concerning the lack of occupations for women affected with IPV in all areas of ADL, IADL, education, leisure, and sleep/rest (American Occupational Therapy Association, 2014). This warrants the role of occupational therapy in OD of women affected by IPV as a priority area of research.

Discussion

The dangerous nature of IPV on women requires the collaborative work of healthcare, social work, and safety and security professionals to address OD among women surviving IPV. The roles of the different disciplines on improving occupational opportunities for women barred with OD have been reviewed however there are several challenges that still warrant

improvement to provide women with occupational justice. OD is described as a condition in the environment in which individuals for reason beyond their control are unable to participate and engage in occupations necessary for their spiritual, mental, physical, or economic well-being for extended periods (Whiteford, 2010). The research supports personal accounts from women described as being occupationally deprived with IPV being the main cause (Anderson & Saunders, 2003; Sullivan et al., 2005; Hyman et al., 2006; Meyer, 2012). IPV is a known public health issue with currently over one third of American women (35.6%) experiencing rape, physical violence, and or stalking by an intimate partner in their life (Black et al., 2011) contributing to their lack of meaningful occupations and performance. IPV is continued today (WHO, 2016) due to the complex nature of the cycle of abuse (Hamberger & Larsen, 2015) and stagnant action by many disciplines. So how can disciplines collaborate to address this problem?

Psychology's specialty in addressing the mental health of individuals faced with trauma such as isolation, insecurity, depression, and abuse are essential in rehabilitating women severely affected by IPV. The professional help of psychologists/counselors with this population is often inaccessible to women especially when women in poverty are more likely to be affected by IPV (Jewkes, 2002). The implementation of counselors with psychology backgrounds in equal access clinics, women's clinics, or even safe phone lines are some ways women can easily start to open up about their experiences. The discipline also helps researchers understand the nature of IPV and how this knowledge may apply to many practices (Lohman, Neppl, Senia, & Schofield, 2013). Similarly, psychologists and other health professionals such as nurses, therapists, and aides may be the first point of contact for many women affected by IPV

therefore healthcare education systems should incorporate screening for individuals affected by IPV.

The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) is a position adopted by the United Nations that mandates the protection and equal opportunity for women by recommending specifics to nation-states on how to eliminate violence against women and girls. The United States has not adopted this position however social work has made strides to protect women such as the establishment of certification programs that focus on group/individual counseling using psychoeducational methods to change beliefs, attitudes, and behavior of perpetrators while encouraging them to own responsibility for their violence (Edleson, Lindhorst, & Kanuha, 2015). Other initiatives such as the passing of the Violence Against Women Act (VAWA) in 1994 have expanded over the past two decades however IPV must be revisited at the policy level through passage of newer and stronger legislation to get more disciplines and individuals involved in enabling occupational opportunities for women. A role of social work is providing resources for women who are challenged by life circumstances such as affordable housing, support groups, shelters, food pantries, and help to get back or start work (Edleson, Lindhorst, & Kanuha, 2015) for women recovering from IPV. For women experiencing IPV addressing the protection and safety is of utmost importance.

Such groups of professionals that can make a greater impact on the safety of women would be the role of safety personnel such as law enforcement at local, state, and national levels. Cerulli et al. (2015) reported that in New York, domestic violence incident reports (DVIR) were processed 54% more often when an injury occurred instead of each time a domestic

dispute was reported. This discrepancy may be one way to detect women barred by IPV and OD. The New York law mandates specific documentation under all circumstances meeting any relationship and crime at the scene of any domestic dispute, yet many reports and incidents may still be covered or unrecorded (Cerulli, Edwardsen, Hall, Chan, & Conner, 2015). Even with policy mandates there are still professional roles that need improvement. The results of the study imply revisiting law enforcement educational and ethical practice.

The occupational determinants of an area, which include its economic, policy, and cultural environment govern the accepted forms of, and opportunities for, occupational engagement (Whiteford, 2010). Does America provide enabling opportunities for women at the economic, policy, and cultural level? On average, full-time workingwomen are paid 78 cents compared to the dollar that a man makes, which perpetuates a male dominant society (The White House, 2016). Policy for protection and elimination of discrimination of women is still non-existent despite the movements of surrounding nations (Edleson, Lindhorst, & Kanuha, 2015) and American social media is inundated with women displayed as sexual figures and viewed as subordinate (Baker, 2005). If the environment does not enable groups of people then those groups are asserted with scenarios of injustices leading to OD (Whiteford, 2010). Occupational science addresses OD and injustices in populations by disseminating research in understanding experiences and testing out interventions performed by occupational therapists (OTs) (Molineux, 2010). Therefore. research disseminating information about understanding women who have experienced/experience IPV is essential for professionals to provide client-centered services by using an occupational justice framework (Whiteford, 2010).

In studying OD as and occupational science construct it is important to generalize occupational science jargon (i.e. occupational deprivation, occupational justice, occupational alienation, marginalization, and occupational disruptions) among different disciplines as well a consistently using terms to describe IPV as a single phenomenon (i.e. domestic violence and abuse mean IPV).

Conclusion

Overall accountability of service providers who work with women affected by IPV such as healthcare professionals, social workers, and safety & security personnel should be reviewed and progress to implement new practices. One step in addressing each professions issues is through an assessment of perspectives of service providers. This may be assessed through the Survivor-defined Advocacy scale (SDAS). The scale assesses overall client centeredness and trustworthiness in services provided to women affected by IPV and measure if services are truly survivor-defined. The assessment looks at victim blaming as a concern and supports client's independent decision making. The revision of the SDAS determines service providers attitudes about their work and is useful to clients because it obtains providers baseline perceptions of their responsibilities and is useful to researchers as an efficient measure of survivor defined attitudes of IPV at local state and national agency levels (Kulkarni, Herman-Smith, & Ross, 2015). Collaborative actions implemented throughout the phases of IPV may be the catalyst for reduction and elimination of violence against women globally.

Limitations

The exploratory research focused on the professions of nursing, psychology, social work, law enforcement, and occupational therapy; therefore, our literature search did not include all

potential service providers of women affected by IPV. IPV is a complex and traumatizing cycle that warrants different skills from professionals other than the disciplines included in this exploratory paper. Another limitation to our search was the focus on violence against women because of the prevalence of IPV in this gender group. Additionally, the exploration of violence that occurred within heterosexual relationships was solely researched due to the lack of knowledge and literature of IPV within homosexual relationships. Lastly the exploratory paper focused on solutions for programs within the United States (U.S.) instead of taking an international platform in addressing IPV as there are many cultural differences outside of the U.S. however, research on how IPV affects women immigrants was accounted for.

References

American Occupational Therapy Association. (2007). Occupational therapy services for individuals who have experienced domestic violence (Statement). *American Journal of Occupational Therapy, 61* 704-709. doi: 10.5014/ajot.61.6.704

American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy*, *68*(Suppl. 1), S1-S48. doi:10.5014/ajot.2014.682006

Anderson, D. K., & Saunders, D. G. (2003). Leaving an abusive partner: An empirical review of predictors, the process of leaving, and psychological well-being. *Trauma, Violence, & Abuse*, *4*(2), 163–191. https://doi.org/10.1177/1524838002250769

Arias, I., & Corso, P. (2005). Average cost per person victimized by an intimate partner of the opposite gender: A comparison of men and women. *Journal of Violence and Victims, 20* 379-391. doi:16250406

Blaney, E. (2010). Police officers' views of specialized intimate partner violence training. *Policing, 33*(2), 354-375. doi: 10.1108/13639511011044939

Bacchus, L., Bullock, L., Sharps, P., Burnett, C., Schminkey, D…, & Campell, J. (2016). Opening the door: A qualitative interpretive study of women's experiences of being asked about IPV and receiving an intervention during perinatal home visits in rural and urban settings in the USA. *Journal of Research in Nursing, 21* 345-364. doi: 10.1177/1744987116649634.

Baker, C. N. (2005). Images of women's sexuality in advertisements: A content analysis of black- and white-oriented women's and men's magazines. *Sex Roles*, *52*(1-2), 13–27.

https://doi.org/10.1007/s11199-005-1190-y

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merric, M. T., . . . Stevens, M. R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report*. Atlanta, GA: National Centers for Injury Prevention and Control, Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention. (2016). *Intimate Partner Violence: Risk and Protective Factors*. Retrieved from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html

Cerulli, C., Edwardsen, E. A., Hall, D., Chan, K. L., & Conner, K. R. (2015). Improving coordinated responses for victims of intimate partner violence: Law enforcement compliance with state-mandated intimate partner violence documentation. *Violence Against Women*, *21*(7), 897–907. https://doi.org/10.1177/1077801215584072

Chronister, K., & McWhirter, E. (2003). Applying social cognitive career theory to the empowerment of battered women. *Journal of Counseling & Development, 81*(4), 418–425. doi:10.1002/j.1556-6678.2003.tb00268.x

Clough, A., Draughon, J. E., Njie-Carr, V., Rollins, C., & Glass, N. (2014). "Having housing made everything else possible": Affordable, safe and stable housing for women survivors of violence. *Qualitative Social Work*, *13*(5), 671–688. https://doi.org/10.1177/1473325013503003

Copp, J. E., Giordano, P. C., Manning, W. D. and Longmore, M. A. (2016), Couple-level economic and career concerns and intimate partner violence in young adulthood. *Family*

Relationships, 78: 744–758. doi:10.1111/jomf.12282

Corvo, K., & Johnson, P. (2013). Sharpening Ockham's Razor: The role of psychopathology and neuropsychopathology in the perpetration of domestic violence. *Aggression and Violent Behavior*, *18*(1), 175–182. https://doi.org/10.1016/j.avb.2012.11.017

Edleson, J., Lindhorst, T., & Kanuha, V. K. (2015, November). Ending Gender-Based Violence: A Grand Challenge for Social Work. American Academy of Social Work and Social Welfare.

Gorde, M., Helfrich, C., & Finlayson, M. (2004). Trauma symptoms and life skill needs of domestic violence victims. *Journal of Interpersonal Violence, 19*(6), 691–708. doi:10.1177=0886260504263871

Hamberger, L. & Larsen, S. (2015). Men's and women's experience of intimate partner violence: A review of ten years of comparative studies in clinical samples; Part I. *Journal of Family Violence, 30* 699-717. doi:10.1007/s10896-015-9732-8.

Humbert, T. K., Engleman, K, & Miller, C. E. (2014). Exploring women's expectations of recovery from intimate partner violence: A phenomenological study. *Occupational Therapy in Mental Health, 30*(4) 358-380. doi: 10.1080/0164212X.2014.970062

Hyman, I., Mason, R., Berman, H., Gurge, S., Manuel, L., Kanagaratnam, P.,...Tarcicius, R. (2006). Perceptions of and response to women abuse in Tamil women in Toronto. *Canadian Woman Studies, 25*(1,2) 145-150.

Iwama, M. (2010). Cultural perspectives on occupation. In C. H. Christensen & E. A. Townsend (Eds)., *Introduction to occupation: The art and science of living* (pp. 35-53). Upper Saddle River, NJ: Pearson Education Inc.

Jewkes, R. (2002). Intimate partner violence: Causes and prevention. Lancet (London, England),

359(9315), 1423-1429.

Kulkarni, S., Herman-Smith, R., & Ross, T. C. (2015). Measuring Intimate Partner Violence (IPV) Service Providers' Attitudes: The Development of the Survivor-Defined Advocacy Scale (SDAS). *Journal of Family Violence*, *30*(7), 911–921. https://doi.org/10.1007/s10896-015-9719-5

Lohman, B. J., Neppl, T. K., Senia, J. M., & Schofield, T. J. (2013). Understanding Adolescent and Family Influences on Intimate Partner Psychological Violence During Emerging Adulthood and Adulthood. *Journal of Youth and Adolescence*, *42*(4), 500–517. https://doi.org/10.1007/s10964-013-9923-7

Meyer, S. (2012). Why women stay: A theoretical examination of rational choice and moral reasoning in the context of intimate partner violence. *Australian & New Zealand Journal of Criminology, 45,* 179-193. doi: 10.1177/0004865812443677

Molineux, M. (2010). Occupational science and occupational therapy: Occupation at center stage. In C. H. Christensen & E. A. Townsend (Eds)., *Introduction to occupation: The art and science of living* (pp. 359-382). Upper Saddle River, NJ: Pearson Education Inc.

Murphy, S. B., & Quimet, L. V. (2008). Intimate partner violence: A call for social work action. *Health & Social Work, 33*(4), 309-14. Retrieved from http://search.proquest.com.ezproxylocal.library.nova.edu/docview/210555487?accountid=6579

Phelan, M. B., Hamberger, L. K., Guse, C. E., Edwards, S.,Walczak, S., & Zozel, A. (2005). *Domestic violence among male and female patients seeking emergency medical services. Violence and Victims, 20*, 187–206.

Sullivan, C., Nguyen, H., Allen, N., Bybee, D., & Juras, J. (2000). Beyond searching for deficits: Evidence that physically and emotionally abused women are nurturing parents. *Journal of Emotional Abuse, 2*(1), 51–71.

Sullivan, M., Senturia, K., Negash, T., Shiu-Thornton, S., & Giday, B. (2005). "For us it is like living in the dark": Ethiopian women's experiences with domestic violence. *Journal of Interpersonal Violence*, 20,922–940.

Tanha, M., Beck, C. J. A., Figueredo, A. J., & Raghavan, C. (2010). Sex differences in intimate partner violence and use of coercive control as a motivational factor for intimate partner violence. *Journal of Interpersonal Violence, 25,* 1836–1854.

Wilcock, A.A. (1998). *An occupational perspective of health. Thorofare, NJ: Slack, Inc*

The White House. (2016). *Did you know women are still paid less than men?* Retrieved from https://www.whitehouse.gov/equal-pay/career

Whiteford, G. (2010). Occupational deprivation: Understanding limited participation. In C. H. Christensen & E. A. Townsend (Eds)., *Introduction to occupation: The art and science of living* (pp. 303-325). Upper Saddle River, NJ: Pearson Education Inc.

World Health Organization [WHO] (2016). Violence against women. Retrieved from http://www.who.int/mediacentre/factsheets/fs239/en/

Zufferey, C., Chung, D., Franzway, S., Wendt, S. & Moulding, N. (2016). Intimate partner violence and housing: Eroding women's citizenship. *Journal of Women and Social Work,* 1-16. doi: 10.1177/0886109915626213

Occupation: December 2018 Issue

A Need for Occupational Justice: The Impact of Racial Microaggression on Occupations, Wellness, and Health Promotion

Emily Grullon, Carlneshia Hunnicutt, MeLisa Morrison, Olandria Langford, and Mirtha Whaley

Nova Southeastern University

Abstract

"Ism," in general terms describes a practice that denotes oppression of a group based on the characteristics of its members: racism, sexism, and ageism, are the three types most commonly identified. "Isms" often impose limits on people, and while we have been aware of those limits at the macro level, we have been less aware of acts that happen at the level of the individual, the micro level. These acts, which are frequently heard and seen in the media, have personal, occupational, and health implications for those affected by them. The purpose of this paper is to raise awareness about the issue of racial microaggression and, from occupational therapy and occupational science perspectives, explore how it impacts engagement in valued occupations, wellness, and health. This paper aims to encourage scientific discourse among practitioners, students, and educators so that we can truly be client-centered and culturally effective advocates for inclusion and participation in life.

Keywords: social justice, occupational therapy, prejudice, "ism", discrimination, occupational justice, microaggression, occupation, wellness, health, power

Occupation: December 2018 Issue

A Need for Occupational Justice: The Impact of Racial Microaggression on Occupations, Wellness, and Health Promotion

Introduction

"Ism," in general terms, refers to a doctrine, theory, or practice. When applied to societal attitudes about specific groups of people, "ism" describes a practice that denotes oppression of a group based on the characteristics of its members with racism, sexism, and ageism, being the three types most common identified. "Isms" of any kind, often impose limits at the macro or societal level, on the groups affected, such as institutionalized or systemic limits of work, and social roles based on these "isms." However, missing from our societal and professional radars, are those acts that happen on a daily basis which are intended to demean, invalidate, intimidate, and limit individuals: acts of microaggression that may be heard and seen in the media, but are misunderstood in terms of the occupational and health impact they have.

Racism is a form of privilege and oppression defined as "a societal system in which actors are divided into 'races', with power unevenly distributed (or produced) based on these racial classifications (Paradies, 2006, pg. 145). Racism is identified as a source of structural pressure that gives rise to lack of equal access to opportunities at the macro level (Oliver, 2001; Beagan & Etowa, 2009). In American history, racism has evolved from the more overt forms such as slavery and segregation, to covert and more subtle forms of contemporary racism, described as racial microaggressions. Racial microaggressions ultimately lead to power imbalances, which create occupational barriers and injustices at the level of the individual...the micro level (Beagan & Etowa, 2009). Although racist beliefs within a society are generally

observed at the sociocultural or macro level, they are actually operant and perpetuated at the level of the individual...the microlevel, which has a direct effect on the individual's occupational opportunities and well-being.

Problem Statement

Racial microaggressions, a term often used to define contemporary acts of racism, have limited many individuals from the freedom to engage in meaningful occupations. Sue et al. (2007) defines microaggressions as "brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group" (p.273). Examples of microaggressions include, but are not limited to: discrimination and prejudices based on race, gender, or age, use of racial slurs, and dismissive attitudes towards an individual's lived experiences. The negative stressors associated with microaggressions have a direct influence on wellness and health promotion, as well as the following occupations: activities of daily living (ADLs), instrumental activities of daily living (IADLs), rest and sleep, leisure and play, social participation, and work and education. Within the United States (U.S.), people of color, otherwise known as minority groups, are stripped of their freedom to engage in meaningful occupations due to predispositions of racism and other discriminatory feelings toward them. These attitudes of exclusion evolve into forms of social and occupational injustices that lead to occupational imbalance and are expressed through the lack of access to meaningful daily occupations (Beagan & Etowa, 2009). Because the focus of occupational therapy is on overcoming barriers to participation in daily life, practitioners have an opportunity to play a vital role in addressing issues of occupational injustice promoted by acts of microaggression (Arnold & Rybski, 2010). Occupational therapists have a duty to advocate for the promotion of

health and wellness, as well as occupational engagement for all individuals served, irrespective of abilities, socioeconomic status, or cultural background.

Definitions

Understanding the broad issue of microaggression requires that the reader become familiar with its many forms. The section that follows offers a review of the concept of occupational justice, and provides definitions and examples of different manifestations of microaggression.

Occupational justice. The *Occupational Therapy Practice Framework: Domain & Process, Third Edition* (OTPF-III) identifies occupational justice as the recognition of every individual's occupational rights to inclusive participation regardless of differences and including but not limited to: age, social class, ability, or gender (Nilsson & Townsend, as cited in American Occupational Therapy Association [AOTA], 2014). Additionally; Townsend and Wilcock (as cited in the OTPF-III) state that occupational justice includes having access to resources to participate in occupations in order to meet personal, societal, and health needs; opportunities for social inclusion; as well as the accessibility and participation in meaningful occupations granted to others (AOTA, 2014). Similarly, Murphy, Griffith, Mroz, & Jirikowic (2017) indicated that occupational justice developed from the concept of social justice, which entails the rights of individuals to engage in desired or needed occupation, and to address equity and access.

Occupational justice expands upon the concept of social justice by including issues that relate to OT such as participation, empowerment, and meaningful activity (Paul-Ward, 2009; Arnold & Rybski, 2010). And yet, as the profession celebrated its Centennial, the US continued

to experience various health and socioeconomic inequities that interfere with well-being, give rise to social unrest (Aldrich, Boston, & Daaleman, 2017) and promote occupational injustices.

Occupational injustice occurs "when participation in occupation is barred, confined, restricted, segregated, prohibited, undeveloped, disrupted, alienated, marginalized, exploited, excluded, or otherwise restricted" (Townsend and Wilcock, as cited in Paul-Ward, 2009, p. 83). WFOT (2006) states "abuses of the right to occupation may take the form of economic, social or physical exclusion, through attitudinal or physical barriers, or through control of access to necessary knowledge, skills, resources, or venues where occupation takes place". Additional threats to the right to occupation include poverty, disease, social discrimination, displacement, disasters (natural or man-made), and armed conflict (WFOT, 2006). Therefore, continued silence on issues of injustice, such as current ones related to racism in the U.S., promotes the absence of international dialogue regarding occupational justice (Aldrich et al., 2017). Such silence is also indicative of the acceptance of the status quo as there is a failure to challenge or foster change within the social structures that generates and continues marginalization and health inequities (Gerlach, 2015).

Racial microaggression. The face of racism has changed greatly in American history. It is believed that racism has evolved from an "old fashioned form" to more subtle forms of contemporary racism, which have been identified as modern racism (McConahay, 1986), symbolic racism (Sears, 1988), and aversive racism (Dovidio & Gaertner, 2000). Sue et al. (2007) identified commonalities between the three forms of contemporary racism, which highlight that racism may be displayed in a more ambiguous form. The ambiguous manifestation of these forms of contemporary racism make them hard to define once they occur. It has been

suggested that the term racial microaggression is a more appropriate term to highlight the everyday occurrence of contemporary forms of racism. Microaggressions may be intentional or unintentional ways of communicating "hostile, derogatory, or negative racial slights and insults to the target person or group" (Sue et al., 2007). The term racial microaggression encompasses words and interactions that are perceived as racist by the victim, which in turn may lead the victim to carry emotional weight or mental distress (Fleras, 2016). Microaggressions present themselves in many different forms to which have been identified by Sue et al. (2007) as microassaults, microinsults, and microinvalidations. The following definitions are offered to familiarize the reader with the terms.

Microassault. Sue et al. (2007) defines a microassault as, "an explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful discriminatory actions" (p. 273). This form of microaggression is similar to antiquated forms of racism, due to the ill intended actions of the perpetrator (Bleich, 2015). Perpetrators of microassaults usually remain anonymous as these acts mostly take place in private. An example of a microassault would be to use a derogatory name to refer to someone, such as calling a person with Indian features a "dot head". Other examples may be the display of White supremacy.

Microinsult. Sue et al. (2007) defines a microinsult as, "communications that convey rudeness and insensitivity and demean a person's racial heritage or identity" (p. 273). Microinsults are very subtle and oftentimes perpetrators of microinsults do not realize that their comments may be offensive to a person of color. Although everyday forms of racism in the present day may be unintentional, they are indicative of social inferiorities, which may lead

the victim to feel alienated and in turn, question his/her place in society (Beagan & Etowa, 2009; Fleras, 2016). It requires a conscious effort to not participate in the use of microinsults, in a society that systemically structures hierarchical relations of race and racism (Beagan & Etowa, 2009; Sue et al., 2007). An example of a statement entailing a microinsult is “You are a credit to your race".

Microinvalidation. Sue et al. (2007) defines a microinvalidation as, “communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color” (p. 273). An example of this is when a racial minority couple experiences poor services due to discrimination at a restaurant and are told that they are being overly sensitive. Another common example is when a person states, “I don’t see color”, in response to a racial minority's experience of racial discrimination. Each of these examples nullify and diminish the said experiences.

Review of the Literature

A review of the literature was completed to determine how multiple exchanges of microaggressions impact engagement in occupations. Research was found through CINAHL Complete, Medline, and PubMed. Key terms included the following: social justice, occupational therapy, prejudice, “ism”, discrimination, occupational justice, microaggression, occupation, wellness, health, power. The articles were derived from the following disciplines: occupational therapy, sociology, anthropology, and public health. Literature published prior to 2000 were excluded. A total of 22 articles was used to complete the literature review.

Microaggressions have an impact on activities of daily living (ADL's), such as self- care and self-maintenance as well as on instrumental activities of daily living (IADL's). A recent study conducted by Hoffman, Trawalter, Axt, and Oliver (2016) found that medical students believed Black skin was thicker than White skin. Additionally, individuals with Black skin were believed to have a higher pain tolerance. These microinvalidations resulted in improper medical treatment of individuals with black skin (Hoffman et al., 2016). Beliefs such as these contribute to the present racial disparities which impact wellness and impact how minorities manage their health. Another study by Watson and Downe (2017) investigated the discrimination Romani women experienced from health professionals working in maternity wards. Roma women who are of darker skin, reported multiple cases of being mistreated, including: poor communication; being abandoned; being physically and verbally abused; being refused care; and having to wait until non-Roma women were helped (Watson & Downe, 2017); all indicative of microinvalidations, microinsults, and microassaults.

In Canada, a study by Tang, Browne, Mussell, Smye, and Rodney (2015) reported that health care professionals believed that those on welfare are abusing both the health care system and the hard work of health care professionals. This belief exemplifies a microinsult, as these beliefs are insensitive to the needs of minority groups and those of lower socioeconomic status (Sue et al., 2007). Many could argue that this is one of the reasons that there has been opposition towards the Patient Protection and Affordable Care Act (ACA) in the U.S., along with the expansion of Medicaid in participating states. The ACA attempted to reduce racial and ethnic disparities in health care, which are linked to discrimination (Abdus, Mistry, & Selden, 2015; Pardasani & Bandyopadhyay, 2014).

In terms of racial disparities as related to health care, Blacks and other non-Hispanic minorities rated their self-health as being poor within both minority communities and those communities with mostly White residents, resulting in feelings of localized discrimination. (Gibbons & Yang, 2014). Consequently, the health of Black males has ranked the lowest compared to other racial groups (Gilbert et al., 2016). Personal factors of care recipients, such as education, trust, compassion, respect, affordability, and cultural sensitivity, contributed to limited access to health care (Cutts et al., 2016). Hispanics also reported feeling disrespected by health professionals and this has generated a general distrust in the medical system (Cutts el al., 2016). Studies investigating the importance of sleep and the factors that reduce sleep in individuals who experienced high levels of discrimination, found that shorter periods of sleep were associated with increased risk for depressive symptoms and vulnerability for these individuals, thus influencing their overall health and wellness (Sheikh, Tu, Saini, Fuller-Rowell, & Buckhalt, 2016; Yip, 2015).

Additionally, the literature indicates that racial microaggressions also have an impact on the IADL of child rearing. African Canadian women have had concerns of raising their children to 'deal' with racism (Beagan & Etowa, 2009). These concerns have led African-Canadian parents, as we have also seen in our own domestic media in the past few months, to develop occupational roles as parents that include teaching coping strategies to their children to combat racism. Essentially, microaggressions experienced by past generations have created additional responsibilities for African-Canadian parents. Beagan and Etowa (2009) expressed, “there is no reason to believe the influence of racism on occupation will differ elsewhere” (p. 291), therefore the findings in Canada may be reflective of occurrences in the U.S. Furthermore, as

Aldrich et al. indicate in their 2017 article, occupational therapists in the U.S. have yet to take on the responsibility of addressing occupational injustices within their practice.

Racial microaggression was found to have an impact on leisure occupations pursued by minority groups. Lee (2000) and Beagan and Etowa (2009) found that everyday forms of racism impacted leisure activities such as watching television, going out to dine, shopping and/or attending entertainment and sports events among African-American and African-Canadian women who participated in their studies. Lee (2000) also reported that African-American customers disclosed they were often monitored, scrutinized, and/or followed when shopping. Beagan and Etowa (2009) indicated that African Canadian women reported being ignored and belittled when shopping. These forms of microaggressions can be identified as microinsults and microassaults (Sue et al., 2007).

In the U.S. and Canada, the negative portrayal of minority groups by the media "may influence the self-concepts and beliefs of one's own group and also may generate attitudes and beliefs about such groups among the general public" (Berry, 2000, p. 58). The negative portrayal of minority groups by the media generates negative attitudes and beliefs about these groups. These negative portrayals by the media qualify to be defined as racial microaggressions according to Sue et al.'s (2007) description of hostile, derogatory, or negative racial slights and insults to the target person or group. Beagan and Etowa (2009) found that it was difficult for African Canadian women to relax while watching the television without being on guard for racial slights, thus impacting health and wellness, when pursuing this specific leisure activity.

Microaggressions occur on both conscious and subconscious levels (Spencer, 2017) in various situations that affect social participation. Spencer (2017), described microaggressions as "conversations that happen at our dinner table, college parties, and workrooms among our family members, friends, and co-workers. They are represented in the memes on the Internet, the mascots of teams for which we root, television and movies, classrooms and billboards" (p. 3). Furthermore, it is important to note that racism is a part of the social environment and exists at the macro, meso, and micro levels (Beagan & Etowa, 2009). Microaggressions occur during engagement in community, family, and peer/friend activities, which influence the occupational, social, and environmental domains of wellness. Spencer (2017) explains that microaggressions are most harmful when they are expressed by family, friends, and progressive-minded people. Racial microaggressions are not limited to face-to-face contacts, they also occur in various online contexts (Williams, Oliver, Aumer, & Meyers, 2016). In a recent experimental study, Williams et al. (2016) investigated how the experience of subtle racial discrimination offline may influence perceptions of offensiveness in racially themed memes for both Whites and people of color. Results indicated that, compared to that of their White counterparts, the experiences of people of color with microaggressions in daily everyday settings were predictive of the ratings they assigned to the racially themed internet memes. White participants reported experiencing racial microaggressions offline at least once in the past six months, compared to people of color's report of experiencing racial microaggressions daily (Williams et al., 2016).

It is not uncommon for children to experience microaggressions while pursuing an education. In an exploratory study, Pachter, Bernstein, Szalacha, and Coli (2010) found that

microassaults were the most commonly perceived forms of discrimination among minority children (Sue et al., 2007). In the same study, it was found that minority children also experience microinsults, as teachers would call on them less in class and give their attention to non-minority students. Moreover, many minority youths are falsely accused of acts they did not commit by their teachers (Beagan & Etowa, 2009; Sue et al., 2007). These forms of microassaults and microinsults are linked to development of behavioral problems, depression, anxiety, low self-esteem, and an increased risk of substance abuse in minority children, thus hindering their ability to engage in formal educational participation and negatively affecting wellness (Brody et al., 2006; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Szalacha, Erkut, Garcia Coll, Alarcón, Fields, 2003; Terrel, Miller, Foster & Watkins, 2006; AOTA, 2014).

Latino children have been victims of microaggressions in schools, by teachers and peers, with details of them being discriminated against because of perceived ethnicity and knowledge of a foreign language. These acts are detrimental to a child's well-being in that Latino children are at risk to develop heightened levels of depression (Ayón & Philbin, 2017). Latino youth feared going to class and felt they were treated differently from non-Latino peers. In the form of institutional discrimination, these children were not allowed to speak Spanish in the classroom. In the form of microassaults, Latino children were told that being Mexican was something they should not take pride in (Ayón & Philbin, 2017; Sue et al., 2007). More extreme cases exist where they experienced derogatory comments related to White supremacy from their peers. Additionally, children were also negatively impacted by deportation threats. Collectively, these instances have both an emotional and social impact on Latino youth (Ayón & Philbin, 2017).

In a recent study, Stambaugh and Ford (2015) investigated gifted individuals who were African American, Hispanic, or of low socioeconomic status, and concluded that these individuals were more susceptible to experiencing microaggressions, when compared to their age-matched White counterparts. The study suggested that gifted students who also carry racial and socioeconomic disadvantages have an increased need to be socially accepted and are likely to conform to negative socially accepted views on academics, resulting in academic underachievement. Furthermore, the students lacked resources necessary to develop, meet, or challenge their occupational needs, which intensifies the natural desire for occupational fulfillment. Likewise, these students are oftentimes misunderstood, leading to a misdiagnosis of a disability, perceived behavioral problems, or seeking unnecessary counseling services (Stambaugh & Ford, 2015). Additionally, guidance counselors have been found to encourage less challenging academic courses to those of minority groups, while boosting academic excellence to those in higher social class statuses (Beagan & Etowa, 2009). As it relates to the impact on health and wellness, the outcomes of racial microaggression hinder the academic success and further cause gifted minority students to be reluctantly accepted by peers, teachers, and counselors (Stambaugh & Ford, 2015).

Discrimination in the workplace hinders job advancements and the move toward equality by supporting the systematic perspective of superiority and withholding power and privilege from marginalized groups (Beagan & Etowa, 2009). Beagan and Etowa's (2009) study reported that African Canadian women felt they had to work twice as hard as their co-workers to prove intelligence, skills, and experience; this was true even when workers proved competence and eligibility. Challenging this form of discrimination has its drawbacks, as anyone

in this specific situation may have now jeopardized their position on the job. Additionally, Beagan and Etowa (2009) found that African Canadian women experienced microassults and microinsults in the workplace in the form of outright racial slurs and exposure to comments or questions that were unintentionally offensive (Beagan & Etowa, 2009).

Reflection

Wellness has been defined as "a dynamic way of life that involves action, values, and attitudes that support or improve health and quality of life" (Brownson & Scaffa, 2001, p. 656) Wellness is comprised of eight dimensions, which include the emotional, social, intellectual, physical, spiritual, environmental, financial, and occupational (Substance Abuse in Mental Health Services Administration, 2017). Similarly, the Person-Environment-Occupation-Performance (PEOP) model categorizes the dimensions of wellness into intrinsic and extrinsic factors, which impact a person's well-being and quality of life (Christiansen, Baum, & Bass, 2015). Scaffa, Reitz, and Pizzi (2010) explain how participation is enabled by health.

Utilizing the PEOP model occupational therapists are able to identify barriers to health and create strategies with their clients to optimize engagement in participation (Christiansen et al., 2015). Additionally, Whalley-Hamell (2017) suggests that occupational engagement is central to well-being which evolves into a sense of belonging and self-worth. Occupational therapists often define occupation from a western point of view which often overlooks or fails to recognize the social structures that hinder occupational engagement. Therefore, injustice occurs when opportunities for valuable occupational engagement are unjustly constrained and occupational rights are contravened. Whalley-Hamell (2017) argues that occupational

therapists have the "knowledge and skills to help increase the opportunities available for people to achieve well-being through occupational engagement, especially for all those disadvantaged, marginalized, and vulnerable people whose occupational opportunities are inequitably constrained by the structural factors that shape their lives" (p. 213).

Health and wellness, within the OTPF III, is classified as a concept under health management and maintenance, which the OTPF III considers an instrumental activity of daily living (American Occupational Therapy Association, 2014). Outcomes are defined as result of the occupational therapy process, specifically, outcomes describe what can be accomplished through occupational therapy intervention. Under outcomes, wellness also involves accessibility to resources and is an active process of awareness (American Occupational Therapy Association [AOTA], 2014). Therefore, it is within the scope of practice of occupational therapy to understand how social environments intersect with occupations, as well as how racism impacts a client's occupational performance, meaning, engagement, participation and health (Townsend & Polatajko, 2007).

Discussion

There is support in the literature for occupational therapist's role in social and occupational justice. In fact, the World Federation of Occupational Therapists (2006) states that all individuals have a right to participate in occupations. The right to occupation consists of civic, educative, productive, social, creative, spiritual and restorative occupations which are influenced by cultural, societal, and geographic context (World Federation of Occupational Therapy [WFOT], 2006). However, it has been noted that compared to other countries,

occupational therapists in the U.S., have been slower to adopt the concept of occupational justice (Aldrich et al., 2017). Occupational therapy and the shift toward the biomedical model shapes health as an individual experience, ignoring the influence of social and political structures that cause injustice which negatively impacts health (Wilcock & Hocking, 2015). Whalley-Hamell (2017) suggests that occupational therapists fail to address occupational opportunities that may be available or unavailable due to structural inequalities. In several cases, practitioners only pursue justice as it relates to advocacy and reimbursement, and others often question whether the pursuit of justice is even part of occupational therapy's domain of practice (Aldrich et al., 2017). According to Aldrich et al. (2017), The International Society for Occupational Science (ISOS) suggested that many occupational therapists feel the push toward occupational justice is a part of a political liberal agenda that interferes with the freedom and diversity of practitioners.

As occupational therapists, we pride ourselves on being client-centered; on valuing cultural diversity, cultural sensitivity, and cultural effectiveness; and on promoting social and occupational justice. While individually we may hold those beliefs and possess those attributes, as a profession, we lack the research and the scholarship to inform us about microaggressions, and their impact on occupations and wellness. If we truly embrace the ideal of social and occupational justice, then we have a moral imperative to promote those ideals by facilitating conditions that support the rights of all to resources and occupational engagement.

We begin, by ensuring that practitioners understand the language of “isms;” by raising awareness of the realities faced by individuals who are victimized by microaggressions; by understanding the impact that these realities have on engagement in meaningful occupations

and on wellness (AOTA, 2014); and by remembering that our profession is guided by seven core principles...altruism, freedom, equality, justice, dignity, prudence, and truth (American Journal of Occupational Therapy [AJOT], 1993). We must remember that occupational injustices lead to negative outcomes, and that these include occupational imbalance, occupational deprivation, occupational marginalization, and occupational alienation (Stadnyk, Townsend, & Wilcock, 2011). We must acknowledge that these outcomes of occupational injustices go beyond decreased occupational participation, and that they influence health and quality of life (Stadnyk et al., 2011). We must advocate for a just society where we believe in:

> *An unselfish concern for the well-being of others (altruism); the perception that participation in occupations is a basic human right for all individuals (equality); enabling individuals to demonstrate autonomy in selection of preferred occupations (freedom); providing OT services for individuals affected by occupational barriers and injustices (justice); recognizing the worth and uniqueness of each individual and respect (dignity); upholding accountability and honesty within our attitudes and actions (truth); and utilizing reason to address occupational barriers and injustices (prudence)* (AJOT, 1993; AOTA, 2014).

Our clients are diverse, and they include veterans, refugees, unemployed workers, individuals who don't look like us or have the same sexual preferences, individuals who have limited education, and individuals who have limited health care. We know this, we see them and treat them in our clinics, but the question remains whether we understand and address the occupational injustices they experience (Aldrich et al., 2017). As professionals, we have the responsibility to identify opportunities that benefit underserved populations, as evidenced by

AOTA's inclusion of social justice within the service delivery (Murphy et al., 2017); to identify and address issues of injustices (Whalley-Hamell, 2017); to promote justice by addressing occupational barriers that limit participation in daily activities and to recognize the impact that these have on health and well-being (Pollard, Kronenberg, & Sakellariou, 2008; WFOT, 2006; Whalley-Hamell, 2017). Occupational therapists have the knowledge and skills to promote and support occupation for all individuals; work with groups, communities, and societies; and to identify and raise issues regarding occupational barriers and injustices (WFOT, 2006; Whalley-Hamell, 2017).

Practitioners must commit to developing and consistently utilizing assessments that measure well-being and occupational engagement outcomes, as well as the contextual structural constraints that hinder participation (Whalley-Hamell, 2017). Additionally, occupational therapists can engage in prevention and early intervention, by educating teachers and administrators on how racial microaggressions impact occupations (Ayón & Philbin, 2017). Education, from a systems perspective, can focus on the consequences of discrimination and how these acts of microaggression can be addressed at all levels and prevented (Ayón & Philbin, 2017).

Further research is needed to identify areas where practitioners can bring awareness of the need for occupational justice in the U.S. Ethnographic and/or narrative studies can investigate the impact of microaggressions on occupation. Studies of therapists' perceptions, beliefs, and attitudes about social justice, microaggressions, and our professional responsibilities can help shape educational interventions. (Beagan & Etowa, 2009).

By continuing to use a client-centered approach, with emphasis on occupational engagement and awareness on how microaggressions can be barriers to equitable participation, occupational therapists can support healthy development throughout the lifespan (Ayón & Philbin, 2017), and advocate for policies and conditions that promote social and occupational justice (Ayón & Philbin, 2017). By communicating with interprofessional leaders within the health care system, further awareness on the issue can take place. In turn, these actions may encourage the development of policies which address the role of racism as a social determinant of health (Paradies, 2006; Whalley-Hamell, 2017).

Occupational therapists must also acknowledge their biases, as well as exhibit cultural humility throughout treatment (Whalley-Hammell, 2013). Cultural humility requires practitioners to be critically aware of their own perspectives. Whalley-Hammell (2013) suggests that occupational therapists must be respectful and open to the experiences of their clients regarding the impact of structural inequalities on their occupational opportunities and well-being (Whalley-Hammell, 2013). Lastly, occupational justice must be integrated into the occupational therapy curricula to prepare practitioners with the knowledge and skills to identify and address issues of injustices that create health inequities (Aldrich et al., 2017; Arnold & Rybski, 2010).

While it is important for occupational therapists to acknowledge their own biases when working with people of color, they must also acknowledge "how systematic social power relations shape occupational meanings and engagements" (Beagan & Etowa, 2009, p. 291). By acknowledging the structural inequalities, occupational therapists show understanding of the negative impact racism has on occupational engagement for people of color (Beagan & Etowa,

2009). Occupational therapists must recognize that engagement and motivation are impacted in clients who have experienced racial microaggressions, when participating in certain occupations (Beagan & Etowa, 2009). Due to these occurrences, it is important for occupational therapists to open the discussion of occupational meaning as it relates to the impact of microaggression on health and wellness with people of color, in addition to other marginalized groups in today's society. In conclusion, to support the promotion of a truly client-centered and inclusive practice, it is within the role of occupational therapists to address the impact of racial microaggressions on occupations in order to prevent negative occupational outcomes such as occupational imbalance, occupational deprivation, occupational marginalization, and occupational alienation (Beagan & Etowa, 2009; Stadnyk et al., 2011; Whalley-Hamell, 2017).

References

Abdus, S., Mistry, K. B., & Selden, T. M. (2015). Racial and ethnic disparities in services and the patient protection and affordable care act. *American Journal Of Public Health*, *105*S668-S675. doi:10.2105/AJPH.2015.302892

Aldrich, R. M., Boston, T. L., & Daaleman, C. E. (2017). Justice and U.S. occupational therapy practice: a relationship 100 years in the making. *American Journal Of Occupational Therapy*, *71*(1), 1-5. doi:10.5014/ajot.2017.023085

American Occupational Therapy Association. (2014). Occupational therapy practice framework: domain and process (3rd ed.). *American Journal of Occupational Therapy*, 68(Suppl. 1), S1– S48. http://dx.doi.org/10.5014/ajot.2014.682006

Arnold, M. J., & Rybski, D. (2010). Occupational justice. In *Occupational therapy in the promotion of health and wellness* (pp. 135-156). Philadelphia, PA: F.A. Davis.

Ayón, C., & Philbin, S. P. (2017). "Tú no eres de aquí": Latino children's experiences of institutional and interpersonal discrimination and microaggressions. *Social Work Research*, *41*(1), 19-30. doi:10.1093/swr/svw028

Beagan, B. L., Etowa, J. (2009). The impact of everyday racism on the occupations of African Canadian women. *Canadian Journal of Occupational Therapy. 76*(4), 285-293

Berry, G. (2000). Multicultural media portrayals and the changing demographic landscape: the psychosocial impact of television representations on the adolescent of color...William T. Grant Foundation Conference on Media and Youth, November 15 and 16, 1999. Journal Of Adolescent Health, 27(2), 57-60.

Bleich, M. R. (2015). Microaggression and its relevance in health care. *Journal Of Continuing Education In Nursing*, *46*(11), 487-488. doi:10.3928/00220124-20151020-13

Brownson, C. A., & Scaffa, M. E. (2001). Occupational therapy in the promotion of health and prevention of disease and disability statement. *American Journal of Occupational Therapy, 55*(6), 656-60.

Christiansen, C., Baum, C. M., & Bass, J. D. (2015). *Occupational therapy: Performance, participation, and well-being* (Fourth edition.). Thorofare, NJ: SLACK Incorporated.

Cutts, T., Langdon, S., Meza, F. R., Hochwalt, B., Pichardo-Geisinger, R., Sowell, B., & Jones, M. T. (2016). Community health asset mapping partnership engages Hispanic/Latino health seekers and providers. *North Carolina Medical Journal*, *77*(3), 160-167. doi:10.18043/ncm.77.3.160

Dovidio, J. F., & Gaertner, S. L. (2000). Aversive racism and selective decisions: 1989–1999. Psychological Science, 11, 315–319.

Fleras, Augie. (2016). Theorizing micro-aggressions as racism 3.0: shifting the discourse. Canadian Ethnic Studies. 48. 1-19. 10.1353/ces.2016.0011.

Gerlach, A. J. (2015). Sharpening our critical edge: occupational therapy in the context of marginalized populations. Canadian Journal of Occupational Therapy, 82, 245–253. https://doi.org/10.1177/0008417415571730

Gibbons, J., & Yang, T. (2014). Self-rated health and residential segregation: how does race/ethnicity matter?. *Journal Of Urban Health: Bulletin Of The New York Academy Of Medicine*, *91*(4), 648-660. doi:10.1007/s11524-013-9863-2

Gilbert, K. L., Ray, R., Siddiqi, A., Shetty, S., Baker, E. A., Elder, K., & Griffith, D. M. (2016). Visible and invisible trends in black men's health: pitfalls and promises for addressing racial, ethnic, and gender inequities in health. *Annual Review of Public Health*, *37*, 295-311. doi:10.1146/annurev-publhealth-032315-021556

Hoffman K.M., Trawalter, S., Axt, J.R., Oliver, M.N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between Blacks and Whites. *Proceedings of the National Academy of Sciences of the United States of America, 113*(16), 4296-4301. doi:10.1073/pnas.1516047113

Lee, J. (2000). The salience of race in everyday life: Black customers' shopping experiences in Black and White neighborhoods. *Work and Occupation, 27*, 353-376.

McConahay, J. B. (1986). Modern racism, ambivalence, and the Modern Racism Scale. In J. F. Dovidio & S. L. Gaertner (Eds.), Prejudice, discrimination and racism (pp. 91–126). Orlando, FL: Academic Press.

Murphy, A. D., Griffith, V. M., Mroz, T. M., & Jirikowic, T. L. (2017). Primary care for underserved populations: navigating policy to incorporate occupational therapy into federally qualified health centers. *American Journal of Occupational Therapy*, *71*(2), 1-5. doi:10.5014/ajot.2017.712001

Nilsson, I., & Townsend, E. (2010). Occupational jus- tice—Bridging theory and practice. *Scandinavian Jour- nal of Occupational Therapy, 17,* 57–63. http://dx.doi. org/10.3109/11038120903287182

Oliver, W. (2001). Cultural racism and structural violence. *Journal of Human Behavior in the Social Environment,* 4, 2-3, 1-26. DOI: 10.1300/J137v04n02_01

Pachter, L., Bernstein, B., Szalacha, L., & Coll, C. (2010). Perceived racism and discrimination in children and youths: an exploratory study. *Health & Social Work*, *35*(1), 61-69.

Paradies, Y. (2006). Defining, conceptualizing and characterizing racism in health research. *Critical Public Health*, *16*(2), 143-157.

Pardasani, M., & Bandyopadhyay, S. (2014). Ethnicity matters: the experiences of minority groups in public health programs. *Journal Of Cultural Diversity*, *21*(3), 90-98. Paul-Ward, A. (2009). Social and occupational justice barriers in the transition from foster care to independent adulthood. *American Journal of Occupational Therapy*, 63, 81–88.

Paul-Ward, A. (2009). Social and occupational justice barriers in the transition from foster care to independent adulthood. *American Journal of Occupational Therapy*, 63, 81–88.

Pollard, N., Kronenberg, F., & Sakellariou, D. (2008). A political practice of occupational therapy. In N. Pollard, D. Sakellariou, & F. Kronenberg (Eds.), *A political practice of occupational therapy* (pp. 3–19). Edinburgh, Scotland: Churchill Livingstone.

Scaffa, M. E., Reitz, S. M., & Pizzi, M. (2010). *Occupational therapy in the promotion of health and wellness*. Philadelphia: F.A. Davis.

Sears, D. O. (1988). Symbolic racism. In P. A. Katz & D. A. Taylor (Eds.), *Eliminating racism: Profiles in controversy* (pp. 53–84). New York: Plenum.

Sheikh, M.E., Tu, K.M., Saini, E.K., Fuller-Rowell, T.E., Buckhalt, J.A. (2016). Perceived discrimination and youths' adjustment: sleep as a moderator. *European Sleep Research Society. 23,* 70-77. Doi:10.1111/jsr.12333

Spencer, M.S. (2017) Microaggressions and social work practice, education, and research. *Journal of Ethnic & Cultural Diversity in Social Work, 26*(1-2), 1-5. Doi:10.1080/15313204.2016.1268989

Stadnyk, R., Townsend, E.A., Wilcock, A. (2011). Occupational justice. In Christiansen, C., & Townsend, E.A. Introduction to occupation: the art and science of living (pp. 329-354). London: Pearson Education International.

Stambaugh, T., & Ford, D. Y. (2015). Microaggressions, multiculturalism, and gifted individuals who are Black, Hispanic, or low income. *Journal Of Counseling & Development*, *93*(2), 192-201. doi:10.1002/j.1556-6676.2015.00195.x

Substance Abuse in Mental Health Services Administration. (2017). The eight dimensions of wellness. Retrieved from: https://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness

Sue, D.W., Capodilupo, C.M., Torino, G.C., Buccerci, J.M., Holder, M.B., Nadal, K.L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. *American Psychologist*. 62(4):271–286. doi:10.1037/0003-066X.62.4.271

Szalacha, L. A., Erkut, S., Garcia Coll, C., Alarcón, O., Fields, J. (2003). Discrimination and Puerto Rican children's and adolescents' mental health. Cultural Diversity and Ethnic Minority Psychology, 9, 141-155

Tang, S. Y., Browne, A. J., Mussell, B., Smye, V. L., & Rodney, P. (2015). 'Underclassism' and access to healthcare in urban centres. *Sociology Of Health & Illness*, *37*(5), 698-714. doi:10.1111/1467-9566.12236

Terrel, F, Miller, A. R,, Foster, K., & Watkins, C.EJ. (2006). Racial discrimination—induced anger and alcohol use among Black adolescents. Adolescence, 41, 485—492.

Townsend, E., & Polatajko, H. (2007). Enabling occupation IL Advancing an occupational therapy vision for health, well-being & justice through occupation. Ottawa, ON: CAOT Publications ACE.

Townsend, E., & Wilcock, A. A. (2004). Occupational justice and client-centred practice: A dialogue in progress. *Cana- dian Journal of Occupational Therapy, 71,* 75–87. http:// dx.doi.org/10.1177/000841740407100203

Watson, H.L., Downe, S. (2017). Discrimination against childbearing Romani women in maternity care in Europe: a mixed-methods systematic review. *Reproductive Health, 14*(1). doi:10.1186/s12978-016-0263-4

Whalley-Hammell, K.R. (2013). Occupation, well-being, and culture: theory and cultural humility. *Canadian Journal of Occupational Therapy, 80*(4), 224-234. DOI: 10.1177/0008417413500465

Whalley-Hamell, K.R. (2017). Opportunities for well-being: the right to occupational engagement. *Canadian Journal of Occupational Therapy, 84*(4-5), 209-222 DOI: 10.1177/0008417417734831

Wilcock, A. A., & Hocking, C. (2015). An occupational perspective of health (3rd ed.). Thorofare, NJ: Slack.

Williams, A., Oliver, C., Aumer, K., & Meyers, C. (2016). Racial microaggressions and perceptions of internet memes. *Computers in Human Behavior*, *63*424-432. doi:10.1016/j.chb.2016.05.067

World Federation of Occupational Therapists. (2006). Position statement human rights. Retrieved from http://www.wfot.org/ AboutUs/PositionStatements.aspx

Yip, T. (2015). The effects of ethnic/racial discrimination and sleep quality on depressive symptoms and self-esteem trajectories among diverse adolescents. *Journal Of Youth And Adolescence*, *44*(2), 419-430. doi:10.1007/s10964-014-0123-x

Occupation: December 2018 Issue

The Use of Occupation-Based Interventions in Hand Therapy

Justin Jamison, Rajesh Malikayil

Nova Southeastern University

Abstract

Certified hand therapists (CHTs) provide therapeutic rehabilitative services after injury or illness of the upper extremity (Colaianni, & Provident, 2010). The approaches to interventions that CHTs utilize differ from those more typically used by occupational therapists (OTs) because the approaches to interventions are often primarily based in the medical model of physical disabilities (Robinson, Brown, & O'Brien, 2016). There is growing concern that OTs in hand rehabilitation are not using occupations as a method to intervention, leading the occupational therapy profession away from its foundational tenets (Grice, 2015). Furthermore, according to Colaianni, Provident, Lessa, and Wheeler (2015), there is a certain level of tension present amongst occupational therapy practitioners regarding the use of biomechanical approaches, rather than occupation-based approaches, especially in the hand therapy setting. A review of current research on this topic may provide insight into the effectiveness and potential benefits of implementing the use of occupation-based interventions compared to biomechanically based interventions, in a hand therapy setting.

Introduction-Rationale

Presently, interventions used in the hand therapy setting are often biomechanically based (Grice, 2015). This may have resulted from difficulties with maintaining occupation-based interventions due to use of predetermined treatment protocols and limited time (Colaianni, & Provident, 2010). Although OTs make up the majority of CHTs (Dimick et al. 2009), the use of occupation-based intervention methods are seldom used in the hand therapy setting (Colaianni & Provident, 2010). With current evidence supporting the use of occupation-based interventions in improving overall health and well-being (Christensen & Townsend, 2010), more research needs to be done to ensure clients are receiving optimal care in all healthcare realms. Unfortunately, the current research surrounding the use of occupation-based interventions in hand therapy is lacking. This gap in the research may be limiting the care provided to individuals seeking optimal rehabilitative services in the hand therapy setting.

Problem statement

Many individuals requiring therapeutic services after injury or illness of the upper extremity are referred by their physicians to obtain rehabilitative therapeutic services by a CHT, who is licensed as an OT or PT (Colaianni, & Provident, 2010). According to Christiansen and Townsend (2010), engaging in occupations can have a beneficial effect on an individual's overall health and well-being. With current hand therapy services focused on the use of a biomechanical approach to treatment (Colaianni, & Provident, 2010), it is necessary to explore the potential benefits of using occupation-based methods.

Methodology

In an effort to gain a wide-ranging overview of the issue of the lack of occupation-based interventions in the hand therapy setting, a review of the literature was conducted. Several electronic databases were utilized to help discover articles that were considered pertinent to the topic. These electronic databases included CINAHL Complete, Medline, Google Scholar, and EBSCO Host. Search terms that were used included effectiveness AND occupation-based, occupation-based hand therapy, hand therapy AND interventions, and hand therapy AND occupations. Articles were selected by reading their titles then abstracts for relevance.

Background Literature

According to Grice (2015), hand therapy is a science of rehabilitation that is focused on therapeutic interventions involving the hand, wrist, elbow, and shoulder. Hand therapy services are provided by either an OT or PT who has gained the expertise necessary to deliver dedicated hand therapy services (Kingston, Williams, Judd, & Gray, 2015). Since the majority of hand therapists are licensed as OTs, it could be assumed, or even expected, that the primary methods by which the treatment interventions were delivered would be occupation-based, however, treatment interventions are often delivered using a biomechanical approach (Grice, 2015).

The biomechanical approach is a frame of reference based in the medical model paradigm that uses objective measurements to detail progress of impairments through interventions that are focused on improvement of physical strength, range of motion, and endurance of body functions and structures (Robinson, Brown, and O'Brien, 2016). The biomechanical frame of reference begins with evaluation of the physical structures of the

human body to determine areas of deficit that affect overall functioning (Jackson & Schkade, 2001). Under this approach, it is assumed that body functions have been reestablished once the presenting signs and symptoms have decreased or have been assuaged (Mathiowetz, 1993). Moreover, the biomechanical frame of reference does not necessarily stipulate the inclusion of the client in the participation and collaboration in the treatment intervention (Reed & Sanderson, 1999).

On the other hand, there have been multiple studies shown to provide evidence supporting the use of occupation-based therapy and its successfulness with restoring function (Christensen & Townsend, 2010). Moreover, the occupational-based approach is much more client-centered and focuses more on what is most important to the client (Reed & Sanderson, 1999). One case report by Jack and Estes (2010), describes a client having received hand therapy by a CHT who utilized a biomechanical approach in conjunction with an occupational-based approach. The study concluded that when the client began receiving the occupational-based approach, the client was much more motivated, resulting in increased performance gains when compared to being treated using only the biomechanical type of interventions (Jack & Estes, 2010).

Another study, by Case-Smith (2003), was conducted with 33 clients who were receiving occupational therapy services following guidelines set by the Canadian Occupational Performance Measure (COPM). The results indicated that by using a client-centered approach, as guided by the COPM and after receiving 13 hours of occupational therapy services, clients demonstrated strong, positive gains in functional outcomes (Case-Smith, 2003). One qualitative study, using interpretive phenomenological analysis, was conducted by interviewing 16 OTs

with more than five years of hand rehabilitation experience (Daud, Yau, Barnett, & Judd, 2016). It examined their experiences using occupation-based interventions and concluded that most of the OTs had positive experiences using occupation-based interventions (Daud et al, 2016).

There have been multiple studies completed outside the realm of hand therapy showing the effectiveness of occupation-based interventions. One systematic review, included 39 different studies reviewing the effectiveness of occupation-based interventions post-stroke (Wolf, Chuh, Floyd, McInnis, & Williams, 2015). This study determined the effectiveness of occupation-based interventions by dividing the articles up into five different areas of occupation, including activities of daily living (ADLs), instrumental activities of daily living (IADLs), leisure, social participation, and rest and sleep. The study resulted in the improvement of areas of occupations post-stroke, supporting the use of occupation-based interventions, especially in the areas of ADLs (Wolf et al., 2015).

Furthermore, another systematic review that was conducted, included 38 studies that met the inclusion criteria to examine the effectiveness of occupation-based interventions on community-dwelling older adult's performance of IADLs. The study provided strong evidence to support a client-centered approach and concluded that occupation-based interventions improve IADL outcomes in older adults (Orellano, Colon, & Arbesman, 2012). Through these studies, it becomes clearer that occupation-based interventions not only work in one particular setting. The research suggests that occupation-based interventions have a positive outcome across multiple settings and disciplines.

Reflection

With the majority of CHTs being licensed as OTs, one would assume that the treatments being implemented would be primarily occupation-based. Through this review, however, it has been recognized that the use of a biomechanical approach to treatment design and implementation is more often used. Common themes regarding the use of biomechanically based methods, instead of using occupation-based methods, have been recognized as being affected by the following: a lack of sufficient time, the use of predetermined treatment protocols, and the cooperation and collaboration of treatments with PTs (Colaianni, & Provident, 2010; Grice, 2015; Reed & Sanderson, 1999; Robinson, Brown, & O'Brien, 2016;). Since PTs are not trained in the use and implementation of occupation-based treatment methods, this may be another reason why this approach is not often used.

Through this limited review, a gap in the scientific literature regarding the effectiveness and benefits of implementing occupation-based methods of intervention, specifically in the hand therapy setting, has been identified. Although many articles reviewed contained information regarding the benefits and reasons for using either of the abovementioned approaches, few contained quantitative and/or qualitative data to provide significant evidence for solely adopting either one of the approaches. Some limitations regarding the sole use of the occupation-based method in the hand therapy setting have been identified. With the hand therapy profession consisting of both PTs as well as OTs, incorporating the evaluation and administration of occupation-based treatments in interventions may result in challenges and confusion, due to the lack of foundational occupational perspectives by PTs and the historically perceived efficacy of using biomechanical approaches by OTs.

Discussion/Conclusion

Based on the current literature, a lack of evidence regarding the use of an occupation-based approach versus the biomechanical approach in the hand therapy setting has been identified. Additionally, it is evident that an occupation-based approach to interventions, in combination with the traditional biomechanical approach, is effective in producing positive functional outcome for clients receiving rehabilitation in a hand therapy setting. Although there is limited research about occupation-based interventions in hand therapy, current literature still provides useful and promising information of the effectiveness of occupation-based interventions compared to the traditional biomechanical approach.

With limited evidence and the gap of research, more studies are needed to provide knowledge about the significance of occupation-based interventions using a client-centered approach. This research may identify more effective interventions to which occupational therapy consumers are entitled. It is up to occupational therapy professionals, scholars, and students to go back to their roots, recognize and further research the benefits and effectiveness of occupation-based interventions, and apply these interventions in practice.

References

Case-Smith, J. (2003). Outcomes in hand rehabilitation using occupational therapy services. *The American Journal of Occupational Therapy, 57,* 499-506. doi:10.5014/ajot.57.5.499

Christiansen, C.H. & Townsend, E.A. (Eds.) (2010). Introduction to occupation: The art and science of living (2 ed.). Upper Saddle River, NJ: Pearson Education, Inc.

Colaianni, D., & Provident, I. (2010). The benefits of and challenges to the use of occupation in hand therapy. *Occupational Therapy in Health Care, 24*(2), 130-146. doi:10.3109/07380570903349378

Daud, Z. A., Yau, M., Barnett, F., & Judd, J. (2016). Occupation-based intervention in hand injury rehabilitation: Experiences of occupational therapists in Malaysia. *Scandinavian Journal of Occupational Therapy, 23*(1), 57-66. doi:10.3109/11038128.2015.1062047

Dimick, M. P., Caro, C. M., Kach, M. C., Muenzen, P. A., Fullenwider, L., Taylor, P. A.…Walsh, J. M. (2009). Practice analysis study of hand therapy. *Journal of Hand Therapy, 22*, 361–375.

Grice, K. O. (2015). The use of occupation-based assessments and intervention in the hand therapy setting - A survey. *Journal of Hand Therapy, 28*(3), 300-306. doi:10.1016/jjht.2015.01.005

Jack, J., & Estes, R. (2010). Documenting progress: Hand therapy treatment shift from biomechanical to occupational adaptation. *The American Journal of Occupational Therapy, 64,* 82-87. doi:10.5014/ajot.64.1.82

Jackson, J. P., & Schkade, J. K. (2001). Occupational Adaptation model versus biomechanical–rehabilitation model in the treatment of patients with hip fractures. *American Journal of Occupational Therapy, 55*, 531–537.

Mathiowetz, V. (1993). Role of physical performance component evaluations in occupational therapy functional assessment. *The American Journal of Occupational Therapy, 47*, 225–230.

Orellano, E., Colon, W. I., & Arbesman, M. (2012). Effect of occupation- and activity-based interventions on instrumental activities of daily living performance among community-dwelling older adults: A systematic review. *American Journal of Occupational Therapy*, *66*(3), 292–300. doi:10.5014/ajot.2012.003053

Reed, K. L., & Sanderson, S. N. (1999). *Concepts of occupational therapy.* Baltimore, MD: Lippincott, Williams & Wilkins.

Robinson, L. S., Brown, T., & O'Brien, L. (2016). Embracing an occupational perspective: Occupation-based interventions in hand therapy practice. *Australian Occupational Therapy Journal, 63*(4), 293-296. doi:10.1111/1440-1630.12268

Wolf, T. J., Chuh, A., Floyd, T., McInnis, K., & Williams, E. (2015). Effectiveness of occupation-based interventions to improve areas of occupation and social participation after stroke: An evidence-based review. *American Journal of Occupational Therapy*, *69*(1), 1-14. doi:10.5014/ajot.2015.012195